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ABSTRACT

This document gives information about teenage pregnancy and related issues. The document is divided into 10 sections and then further subdivided into components. The components contain prose summaries with statistical charts. Section 1, Sexuality Activity and Marriage, provides data on trends in premarital sex and marriage rates for black and white adolescents. Section 2, Contraceptive Use, contains data on contraceptive use, choice of contraceptive method, effects of using contraceptives, and reasons for nonuse. The third section, Teenage Pregnancy and Its Resolution, discusses unwanted pregnancy and abortion rates. Section 4, Adolescent Births, compares the adolescent birth rate of the United States to rates of other countries and examines the issues of marriage and adoption. Section 5, Consequences of Teenage Childbearing, presents data on adverse health, social, and economic consequences of teenage pregnancy, including infant death risk, low-birth-weight babies, and financial problems of teenage parents. Section 6, Sex Education, looks at the issue of sex education by state. Section 7 deals with family planning services and contraceptive research. Section 8 provides data on abortion services; section 9 discusses services to pregnant teenagers, adolescent parents, and their babies; and section 10 considers the feasibility of solving the problem of teenage pregnancy. (NRB)

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TEENAGE PREGNANCY: THE PROBLEM THAT HASN'T GONE AWAY

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TEENAGE PREGNANCY: THE PROBLEM THAT HASN'T GONE AWAY

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Introduction

In 1976, The Alan Guttmacher Institute published *11 Million Teenagers*. It was primarily a statistical compilation in chart form of what was then known about adolescent sexuality, contraceptive use, pregnancy, childbirth, abortion and the health and social consequences of teenage childbearing. The chartbook specified services available to prevent adolescent births and to help pregnant teenagers and teenage parents to cope with the serious problems that they faced. More than 220,000 copies of *11 Million Teenagers* were sold and distributed.

The widespread popularity of *11 Million Teenagers* was in large measure due to growing public awareness that teenage sexual activity and pregnancy are not the special problems of any one economic, ethnic or social group, but affect young people from all regions of the country, from the cities and the farms, and from families of all socioeconomic levels, racial groups and religious denominations.

Most people agreed with the major recommendations in *11 Million Teenagers*—to prevent teenage pregnancy through realistic sex education programs and birth control services, to provide pregnant teenagers with an informed choice of maternity or abortion services, and to give pregnant teens, and teenage parents and their children, the health and social services and financial support that they need. Some, however, expressed concern that increasing the availability of sex education and birth control lowered moral standards and encouraged sexual activity among young people, resulting in increased recourse to abortion. Others felt that there had not been sufficient emphasis on the social and behavioral factors involved in teenage pregnancy. The solution of the problem, they maintained, required fundamental changes in family relationships and values to which sex education or the increased availability of medical services such as contraception could contribute little. Still others noted that since the teenage birthrate was in fact declining, the problem was on its way to resolution.

The adolescent birthrate, it is true, has been going down, but the *pregnancy rate* has continued to increase. In 1974, the year referred to in *11 Million Teenagers*, there were one million adolescent pregnancies. By 1978, the year referred to in this publication, that number had increased by 100,000. More than one in 10 teenagers gets pregnant each year, and the proportion is rising. If patterns do not change, four in 10 young women will get pregnant at least once while still in their teens. Despite the declining teenage birthrate, there are 1.3 million children now living with teenage mothers, about half of whom are unmarried. An additional 1.6 million children under age five are living with mothers who were teenagers when they gave birth.

The increase in adolescent pregnancies stems largely from an increase in the number of teenagers who are sexually active. Rising and more consistent use of contraception has not kept pace with this increase. Of course, if

more teenagers abstained from sexual activity, the pregnancy rate could be brought down without increased recourse to contraception. As we will show, however, it is the exceptional young man or woman who gets through the teen years without engaging in sexual intercourse. We live in a society in which marriage and childbearing are being delayed, in which cohabitation is more widespread and accepted and in which all the media glorify youth and sexuality. There is no evidence that in such a setting simply increasing teenagers' fear of pregnancy by barring them from contraceptive and abortion services would do much to decrease their sexual activity. Keeping birth control services and information from teenagers is a singularly cruel as well as ineffective punishment to inflict on young people for responding to messages that many adults may deplore, but appear unable to change. Too many teenagers, far from being encouraged by the availability of birth control, experiment with sex for many months before ever using contraceptives; many, in the meanwhile, become pregnant.

It is a safe assumption that American young people have never embodied the ideal of premarital chastity, even in the days when marriage occured at much younger ages. Premarital pregnancy, out-of-wedlock childbirth and forced marriages of pregnant teenagers have always been common. What is new and probably responsible for increasing public concern about the problem is its increased visibility: The sight of pregnant teenagers is no longer uncommon in school classrooms (previously, a girl was automatically expelled from school if she became pregnant); surveys of teenage sexuality, contraceptive use, pregnancy, abortion and childbirth are widely publicized in the media; fewer teenagers marry to legitimate out-of-wedlock pregnancies, more often choosing either to exercise their new option of legal abortion or to bear and keep their child outside of marriage.

Facing the Facts

This new publication about teenage pregnancy is more comprehensive and detailed than its predecessor. It benefits from the considerable research undertaken in the 1970s. Although this new knowledge has not made us confident that the problem of teenage pregnancy can be solved quickly or simply, we do believe that it can be solved. We know that very few teenagers—very few, certainly, of the great majority who are unmarried—want to get pregnant or to have babies while they are so young. Still fewer of their parents want them to do so. Nor is there any benefit to the society from adolescent childbearing. On the contrary, it is costly to the society both in direct expenditures for health and social services and in the loss of the economic contribution that teenage parents might have made if their educations and vocational choices had not been circumscribed by early childbearing. We know that many teenagers are making great efforts to prevent pregnancy, that more of them are using contraceptives and using them earlier and more consistently than ever before. Many are doing so successfully. Yet pregnancy rates among U.S. teenagers are increasing, and teenage birthrates, though declining, are still among the highest in the world. The decline in births is largely contingent on continued access to legal abortions. While some teenagers, especially those who are older and married, may have births that are wanted and welcomed, the majority of adolescent births, and the overwhelming majority of youthful pregnancies, are unintended. It must be emphasized that unwanted pregnancies, not just unintended births, have adverse consequences for teenagers. Means to prevent both need to be extended.

As we have said, solution of this problem is not simple or single-faceted. In the pages that follow, we attempt to assemble the facts in a way that will make reaching a reasoned solution more possible and less painful than it has been in the past.

SECTION 1

Sexual Activity and Marriage

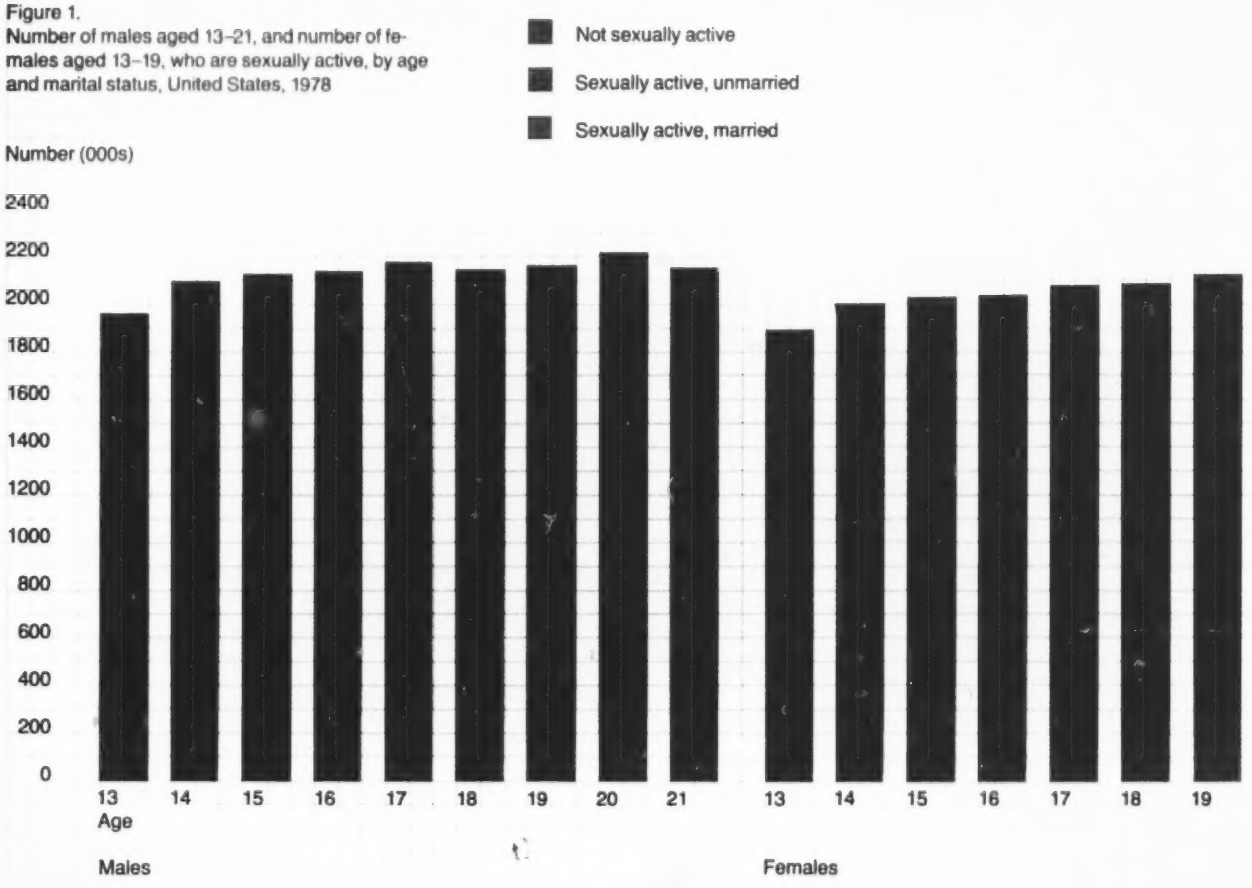
Seven million teenage men and five million teenage women are sexually active. On average, teenagers begin sexual activity at about age 16. It is the exceptional young person who has not had premarital intercourse by age 19. The number of teenagers who are sexually active increased by two-thirds over the 1970s, while the proportion of teenagers married, small to begin with, continued to decline. The increase in teenage sexual activity in recent years is accounted for entirely by unmarried whites.

12 Million Teens Sexually Active; 8 in 10 Men, 7 in 10 Women Experienced by Age 19

Some 12 million of the 29 million young people between the ages of 13 and 19 have had sexual intercourse—about seven million young men and five million young women. Although only 18 percent of boys and six percent of girls aged 13–14 have had intercourse, the proportion sexually experienced rises sharply with increasing age: Nearly half of 15–17-year-old males and one-third of comparable young women are sexually active. It is the exceptional young person who has not had sexual intercourse while still a teenager: Eight in 10 males and seven in 10 females report having had intercourse while in their teens. Only about four percent of teenagers are married, and about 85 percent had intercourse before marriage. Indeed, accidental pregnancy is one of the major factors that bring teenage couples to the altar.

Since the young man is about two years older, on average, than his teenage partner, it may be useful to compare the sexual activity of young women 13–19 years old with that of young men aged 15–21: About five million teenage females and about 9.5 million males aged 15–21 have had intercourse—about half of the young people in these age-groups.

Figure 1.
Number of males aged 13–21, and number of females aged 13–19, who are sexually active, by age and marital status, United States, 1978



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Premarital Sexual Activity Up by 2/3 Over 1970s; Rate for Young Whites Doubles

In the course of the 1970s, sexual activity among unmarried women aged 15–19 living in metropolitan areas rose by two-thirds. By the end of the decade, 46 percent of them reported that they had had intercourse. The increase was most dramatic among whites—especially those aged 15–17, whose rate of sexual activity doubled. Between the middle of the decade and the end, the increase in teenage sexual activity was entirely accounted for by unmarried whites. Although, age for age, the proportion of black teenagers who are sexually active continues to be higher than that of whites, the gap between them has closed considerably.

There has been no significant change in the average age at which young women initiate sexual intercourse—16.4 years for whites and 15.5 years for blacks. The increase in sexual activity, in other words, has been similar at every age. In the early 1970s, race, socioeconomic status, residence and religious affiliation were all related to age at first intercourse. But many of these distinctions are beginning to disappear as premarital sexual activity increases among all elements of the teenage population. A recent survey of United Methodist teens in the North Central United States, for example, showed rates of reported premarital sexual activity among the church-going youths that were similar to those for teenagers generally.

Teen Marriage Rates Drop Over Decade; Down 4% for Whites, but 45% for Blacks

Few young women, and even fewer young men, marry while in their teens. In 1978, just 6.9 percent of young women and 1.6 percent of young men aged 14–19 were married. This compares with 7.7 percent and 2.1 percent of comparable young people 10 years earlier. Although there was only a small decline over the decade in the percentage of white teenagers married, there was a much sharper decrease among blacks—the percentage dropping from 7.7 percent to 3.4 percent of young women, and from 1.4 percent to 0.5 percent of young men. The decline is partially attributable to the decreasing tendency of teens to marry in order to legitimate a premaritally conceived birth.

The increase in sexual activity and the decline in marriage rates would result in a steep increase in premarital pregnancies (and out-of-wedlock births, forced marriages and abortions) unless there were a sufficient increase in contraceptive use among the unmarried to prevent them.

Figure 2.
Percentage of never-married women aged 15–19 from metropolitan areas who have had intercourse, by age-group and race, 1971, 1976 and 1979

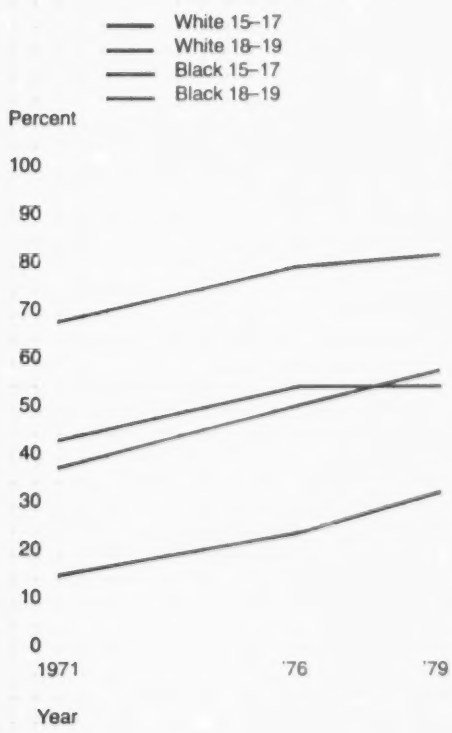
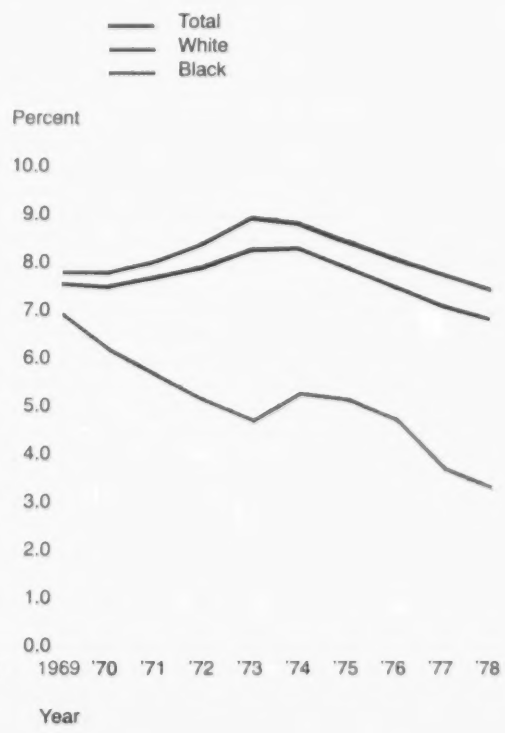


Figure 3.
Percentage of women aged 14–19 who are married, by race, 1969–1978



SECTION 2

Contraceptive Use

The level and consistency of contraceptive use increased over the 1970s, but during the latter half of the decade, the trend of rapidly increasing use of the most effective methods—mainly the pill—was reversed. New users tended to begin sex with less effective methods—most often withdrawal.

Nevertheless, an estimated 680,000 unplanned premarital teenage pregnancies were averted by contraceptive use in one year; an additional 313,000 could have been prevented if all who did not want to get pregnant had used some method consistently.

Contraceptive Use Rises, but Trend Toward Use of Most Effective Methods Is Reversed

The percentage of teenagers who reported using some means to protect themselves against premarital pregnancy rose considerably over the decade. Seven in 10 unwed sexually active teenagers surveyed in 1979 said that they had used a birth control method at last intercourse, compared to only six in 10 in 1976 and five in 10 in 1971. However, although the proportion of teenagers using the *most* effective methods—the pill and IUD—almost doubled between 1971 and 1976, it declined by eight percent in the last part of the decade. On the other hand, the proportion using the *least* effective method, withdrawal, after declining by about 16 percent between 1971 and 1976, grew by 46 percent between 1976 and 1979. Use of the condom, diaphragm and foam—less effective methods than the pill and IUD—also increased during the 1976–1979 period after declining in the first half of the decade.

Because of the rise in the number of sexually active teenagers, an increase of some 636,000 between 1976 and 1979, there were actually about 104,000 more unwed teenagers using the pill and IUD at last intercourse in the latter year than in the former. However, there was also an increase of about 214,000 taking their chances with withdrawal, and only 20,000 fewer teenagers using no method.

The marked trend towards use of the least effective methods is even more apparent when use at *first* intercourse is examined. Teenagers questioned in 1979 were about two and one-half times more likely to have used withdrawal as their method at first intercourse than those surveyed three years earlier. Probably, they have been influenced by the adverse publicity about the dangers of the pill and the IUD—especially in publications that are read most often by young people.

One-Third of Teens Always Used a Method; Half Used Method at 1st Intercourse

Only 27 percent of sexually active teenagers reported in 1979 that they had never used *any* method to protect themselves from pregnancy; 34 percent said that they had consistently practiced contraception, and 39 percent said that they had used contraceptives, but not every time they had intercourse. Forty-nine percent had used a method at their first sexual experience. Between 1976 and 1979, there was a substantial increase in consistent use and use at first intercourse, and a large decline in never-use.

Figure 4.
Percentage of never-married sexually active women aged 15–19 from metropolitan areas, by whether they practiced contraception at last intercourse, according to type of method used, 1971, 1976 and 1979

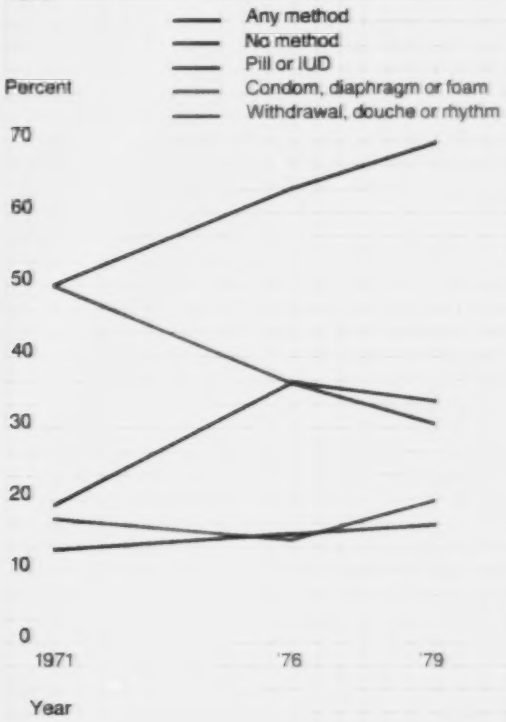
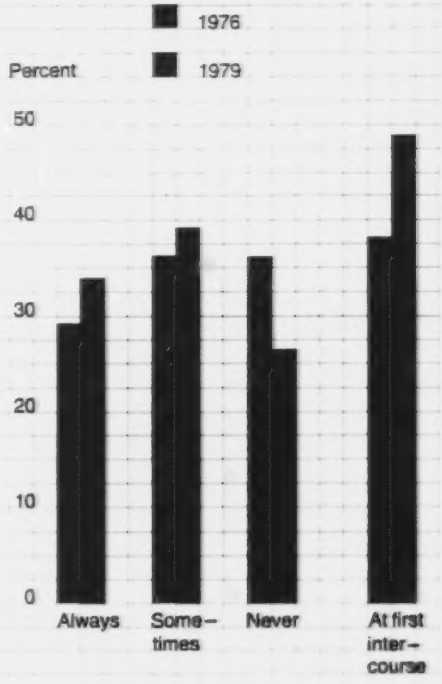


Figure 5.
Percentage of premaritally sexually active women aged 15–19 from metropolitan areas who always, sometimes and never practiced contraception, and percentage who practiced at first intercourse, 1976 and 1979

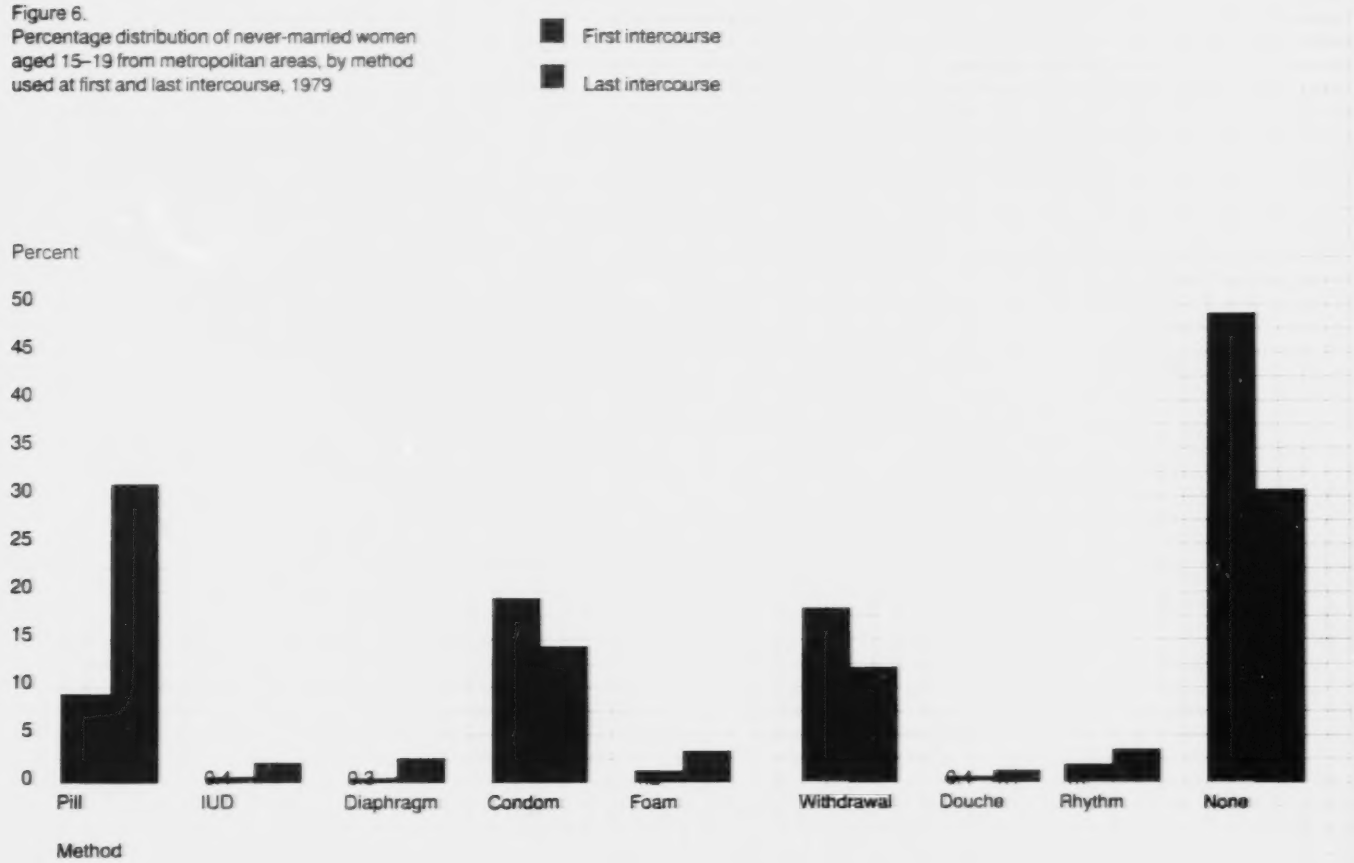


Condom Major Method at 1st Intercourse, But Pill Leads at Most Recent Encounter

In 1979, teenagers reported the condom as the method most often used at first intercourse; this method was followed closely by withdrawal, with the pill a poor third. Three years earlier, the pill was more popular than withdrawal.

At most recent intercourse, the pill was the number-one method choice, although its lead over the condom and withdrawal was not so commanding as it had been in 1976. Many teenagers who use more available nonprescription or folk methods at first intercourse choose orals after experience gives them a better opportunity to weigh the health risks of the pill against the benefits of its increased effectiveness. In a substantial number of cases, however, the "experience" includes an unplanned pregnancy.

Figure 6.
Percentage distribution of never-married women aged 15–19 from metropolitan areas, by method used at first and last intercourse, 1979

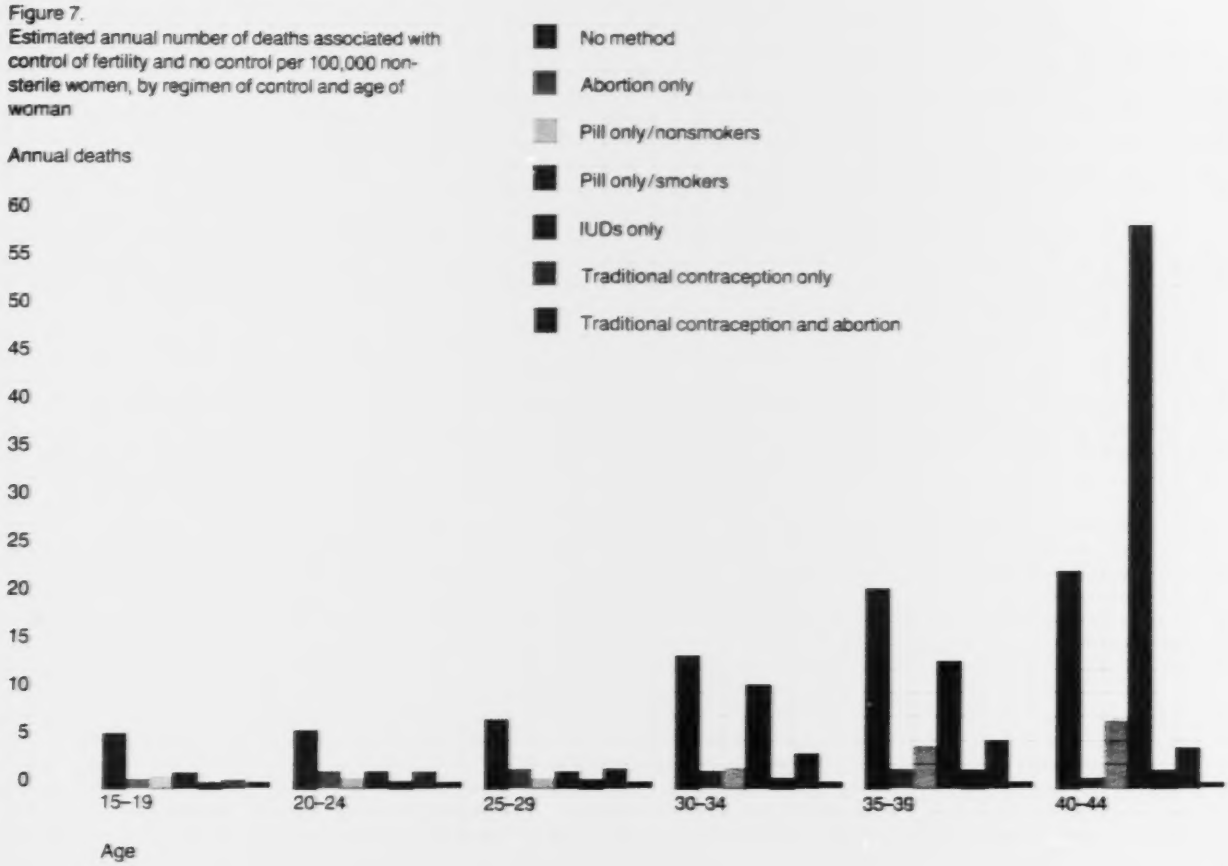


Pill Use Poses Minimum Danger for Teens; Risk Similar to That of Other Methods

Ironically, teenagers, who are most vulnerable to contraceptive failures and unplanned pregnancies and least vulnerable to the adverse health risks of pill use, are apparently the most influenced by publicity about the dangers of oral contraception. Teenagers are five times more likely to die (of pregnancy-related causes) if they use no method of contraception than if they use the pill. And, for teenagers, there has been no significant difference found in the mortality risk from the pill as compared to other methods of birth control. All in all, the annual pill-related mortality rate among teenagers is only 1.2 per 100,000 women. The use of repeated abortions as a backup to failed contraception probably exposes teenagers to a slightly increased risk of problems in successfully carrying later wanted pregnancies to term.

IUD use also poses a minimal risk of mortality to teenagers. However, women who have not had babies are known to have difficulty in using most IUDs successfully. Moreover, the risk of pelvic inflammatory disease (and possible subsequent infertility) and of ectopic pregnancy associated with the IUD—greater than the risk with other methods—raises questions about its suitability for many teenagers.

Figure 7.
Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman



Major Reasons for Nonuse: Ignorance, Unexpected Intercourse, Pregnancy

All in all, nearly two-thirds of unwed teenage women report that they never practice contraception or that they use a method inconsistently. What reasons do they give for nonuse?

Only nine percent say that they did not use a method because they were trying to become pregnant or were already intentionally pregnant.

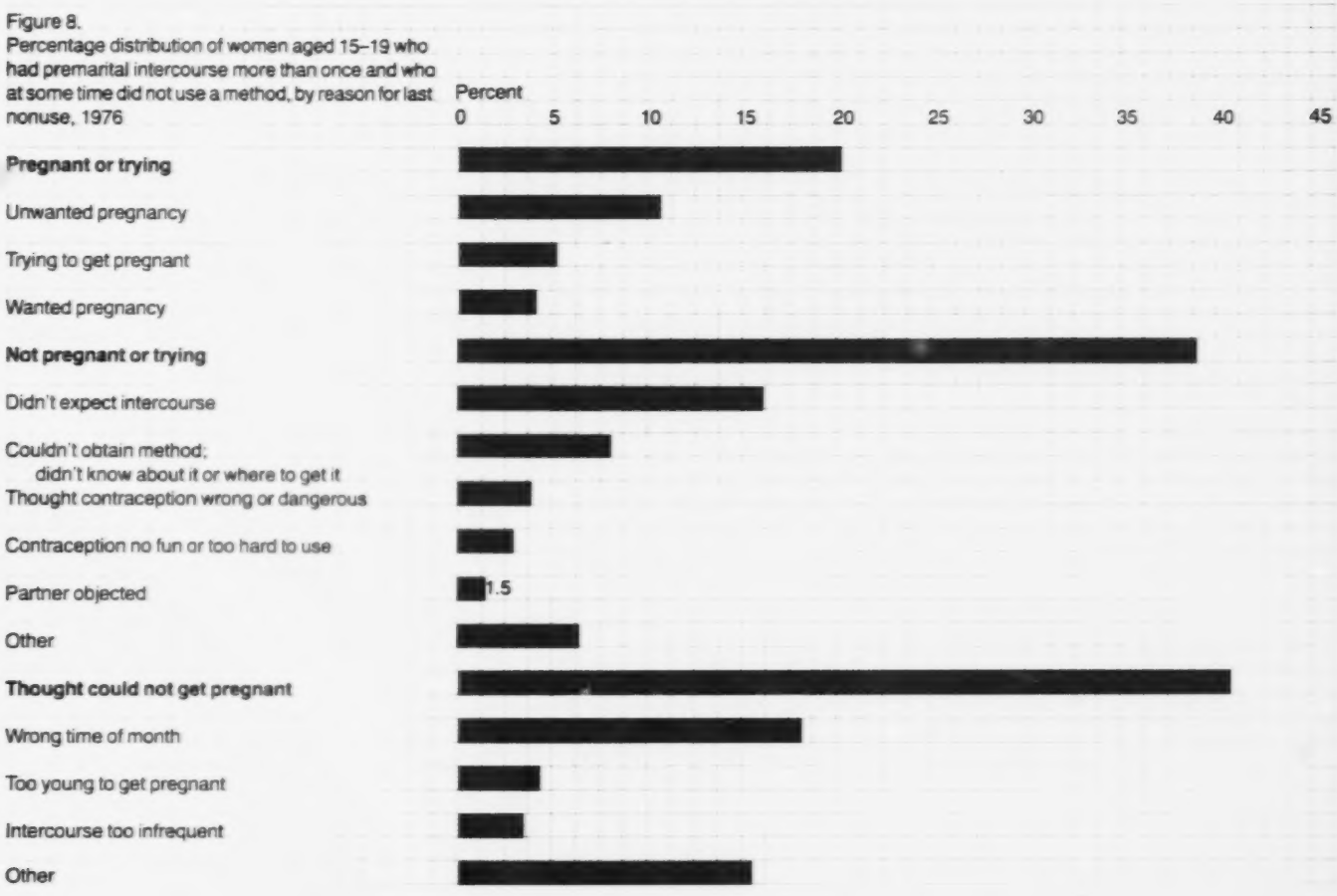
Forty-one percent of unmarried teenagers thought that they could not become pregnant, mainly because they thought—usually mistakenly—that it was the wrong time of the month.

Of those who realized they could get pregnant, the major reason given for not using a method was that they had not expected to have intercourse.

Of the 15 percent who did not practice contraception because they were pregnant, the overwhelming majority were pregnant unintentionally.

About eight percent said that they had wanted to use a method but "couldn't under the circumstances," or that they didn't know about contraception or where to get it.

Figure 8.
Percentage distribution of women aged 15–19 who had premarital intercourse more than once and who at some time did not use a method, by reason for last nonuse, 1976



Contraceptive Use Averted 680,000 Teenage Pregnancies in One Year

The relationship between pregnancy and contraceptive use is dramatic: About 62 percent of sexually active teenagers who have never used a method have experienced a premarital pregnancy, compared to 30 percent of those who have used a method inconsistently, 14 percent of those who have always used some method (including withdrawal), and just seven percent of those who have always used a medically prescribed method (the pill, IUD or diaphragm).

In 1976, teenagers experienced about 780,000 premarital pregnancies. It has been estimated that if no contraceptives had been used, nearly 1.5 million such pregnancies would have occurred. In other words, contraceptive use by unmarried teenagers averted some 680,000 pregnancies.

Had all sexually active teenagers who did not want a baby used some method consistently, about 467,000 premarital pregnancies would have occurred—313,000 fewer than the actual number. If all had consistently used the most effective medically prescribed methods, the number of premarital pregnancies would have been reduced much more.

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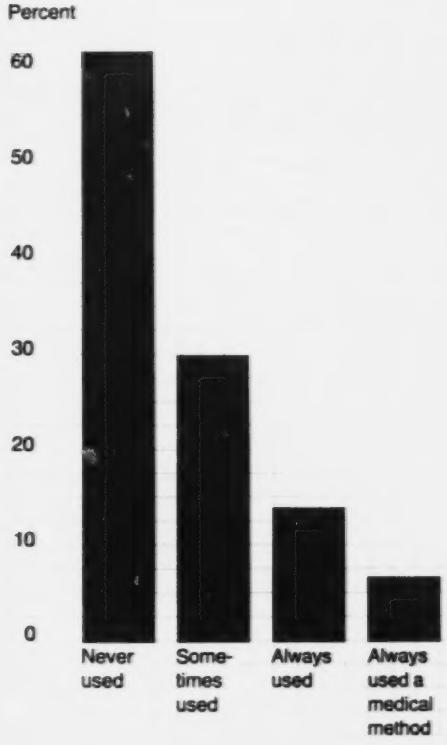
Figure 9.
Percentage of sexually active women aged 15–19 who ever had a premarital pregnancy, by contraceptive-use status, 1979



SECTION 3

Teenage Pregnancy and Its Resolution

The number of pregnancies increased among teenagers in all age-groups during the 1970s, but among those who were sexually active, the pregnancy rate has been declining. In other words, because of increased and more consistent use of contraceptives by teenagers, the rate of pregnancy among them has been increasing more slowly than their rate of sexual activity.

However, because so many teenagers do not use contraceptives at first intercourse, and many more use them inconsistently thereafter, one-fifth of teenage premarital pregnancies occur in the first month after initiation of sex, and half occur in the first six months.

Births conceived following marriage accounted for fewer than one-fifth of the 1.1 million pregnancies resolved by teenagers in 1978. The remainder were aborted or ended as out-of-wedlock births, marital births conceived before marriage or miscarriages.

But very few teenagers want to get pregnant or have babies—especially if they are unmarried. Eight in 10 premarital teenage pregnancies and two-thirds of premarital teenage births are unintended.

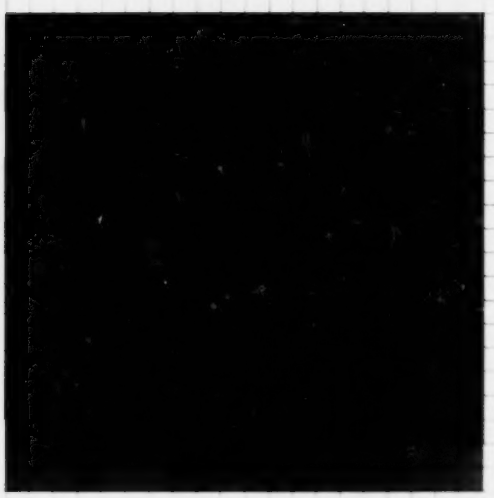
Teenagers represent only 18 percent of sexually active women capable of becoming pregnant, but they account for 46 percent of all out-of-wedlock births and 31 percent of all abortions. If there is no change in current rates, four out of 10 girls who are now 14 will get pregnant in their teens, two in 10 will give birth and three in 20 will have abortions.

1.1 Million Teen Pregnancies in 1978; Most End in Abortions, O.W. Births

About 1,142,000 pregnancies among teenagers were terminated in 1978; 434,000 ended in abortion, and 362,000 resulted in births conceived out of wedlock. Only 192,000—one in six pregnancies—concluded as births conceived following marriage; the remainder were miscarried.

Faced with an out-of-wedlock pregnancy, most teenagers chose abortion (only six percent of abortions among teenagers were obtained by married women). Of those who did not obtain an abortion, 69 percent remained unmarried and 31 percent married to legitimate the birth.

Figure 10.
Percentage distribution of the 1,142,000 pregnancies that occurred among women younger than 20 in 1978, by pregnancy outcome



Abortion Rise Steeper Than Birth Decline; More Abortions Than Births for Youngest

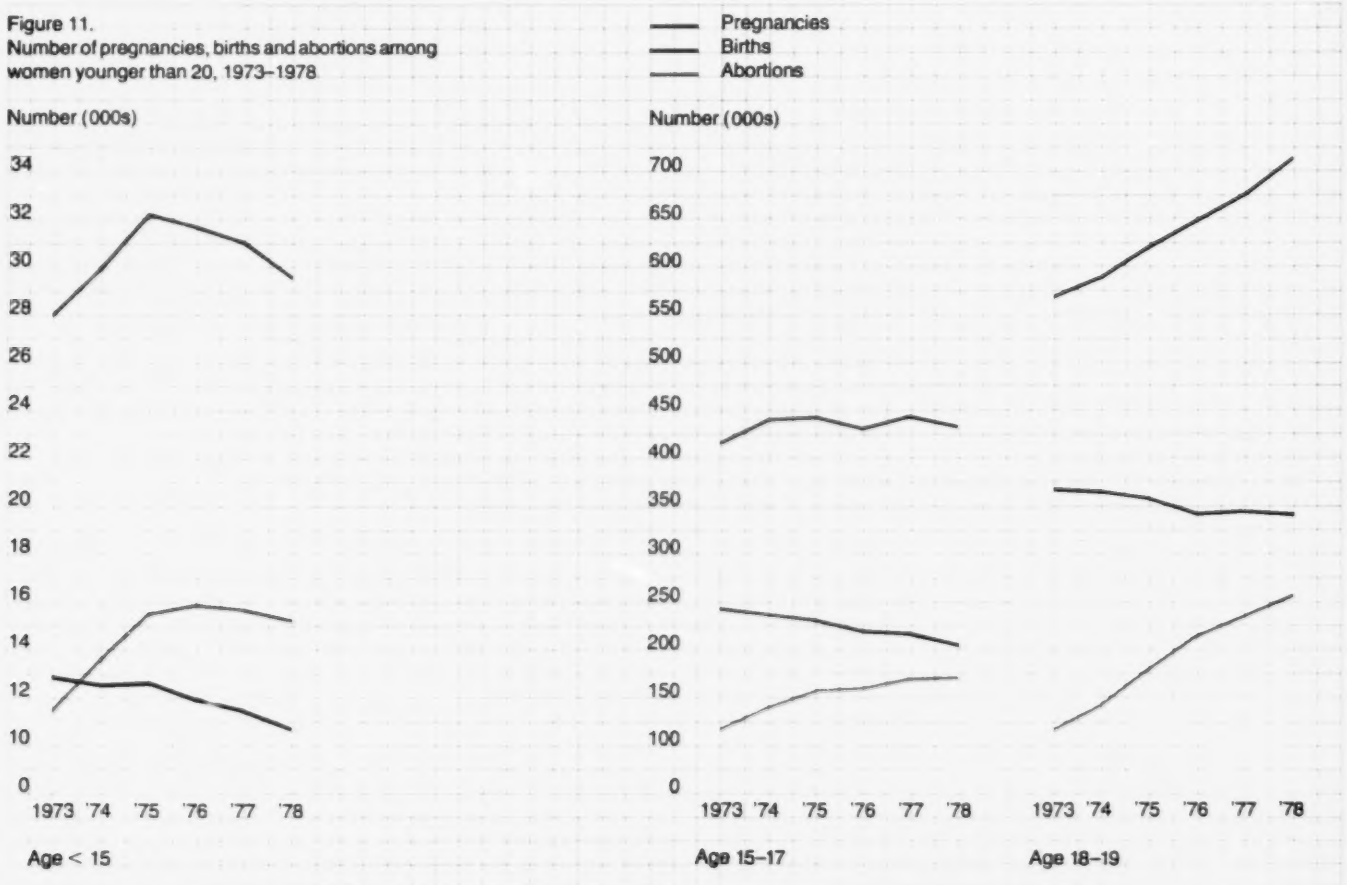
Between 1973 and 1978, there was a 13 percent increase in the number of teenage pregnancies; the increase occurred in every age-group. The rise was steepest among 18–19-year-olds, less dramatic among those aged 15–17 and hardly notable among those under age 15. In 1978, 18–19-year-olds accounted for 685,000 pregnancies; 15–17-year-olds, for 425,000; and girls younger than 15, for 30,000.

Among 18–19-year-olds, the number of pregnancies rose fairly steeply—by 21 percent—following the 1973 Supreme Court decisions. The number of abortions more than doubled, while the number of births declined by only seven percent.

Among 15–17-year-olds, the number of pregnancies rose by only four percent. Abortions increased less steeply (45 percent) among these women than among older teenagers, but births declined more dramatically (15 percent). For the youngest group of teenagers, the number of pregnancies increased by five percent—with abortions up by 31 percent and births down by 17 percent.

The number and rate of pregnancies appeared to be declining in the most recent period for all teenagers under 18, but they continued to rise among older teens. Among those under age 15, abortions surpassed births in 1974, and there are now 1.4 abortions for every live birth among girls in this age-group.

Figure 11.
Number of pregnancies, births and abortions among women younger than 20, 1973–1978



Better Use of Contraceptives Brings Teen Pregnancy Rate Down

Although the proportion of all teenagers who became pregnant rose from 10 to 11 percent between 1973 and 1978, it declined from 27 percent to 23 percent among those sexually active. The decline was sharpest among younger adolescents: The proportion of sexually active 15–17-year-olds who became pregnant fell from more than 26 percent to fewer than 21 percent. The overall teenage pregnancy rate has been rising at a slower pace than the rate of sexual activity because of the greater and more consistent use of contraception by teenagers.

Half of Premarital Pregnancies Occur Within 6 Months of 1st Intercourse

More than one-fifth of first premarital pregnancies among teenagers occur within the first month after the initiation of sexual intercourse; half of the pregnancies occur in the first six months. The younger the age at which a teenager begins intercourse, the more likely that she will become pregnant during the first months of exposure to risk. Any protection afforded by subfecundity at early ages is dissipated by the fact that younger teenagers are relatively less likely to use contraceptives when starting sex. Unwed teenagers who become pregnant in the first months are at particularly high risk of having repeat pregnancies while in their teens; they account for about three-fifths of all repeat premarital pregnancies that occur to teenagers.

Figure 12.
Number of pregnancies per 1,000 women aged 15–19 and per 1,000 sexually active women aged 15–19, by age-group, 1973–1978

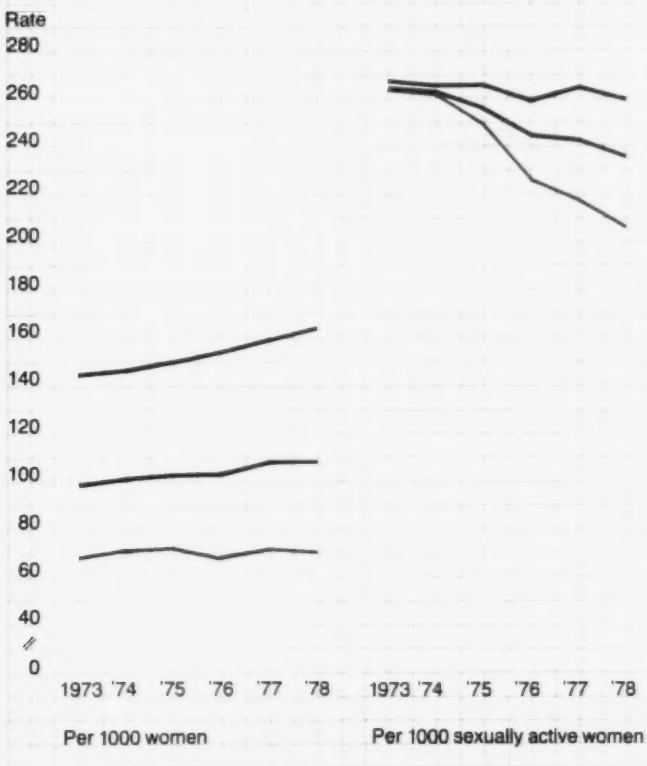
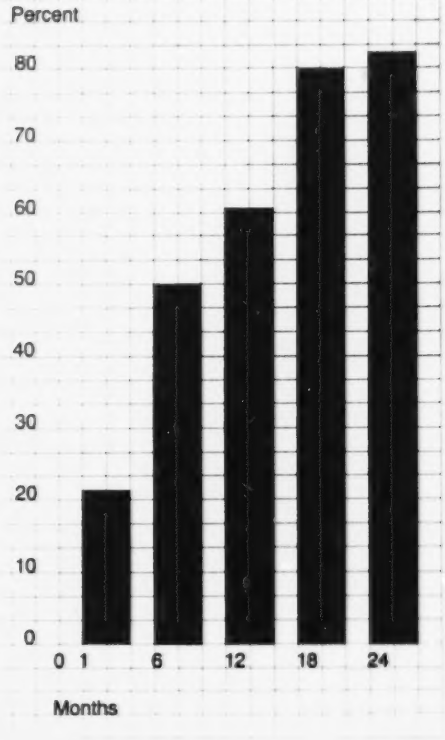


Figure 13.
Estimated cumulative percentage of first premarital pregnancies to women aged 18–19 in 1976, by number of months following first intercourse



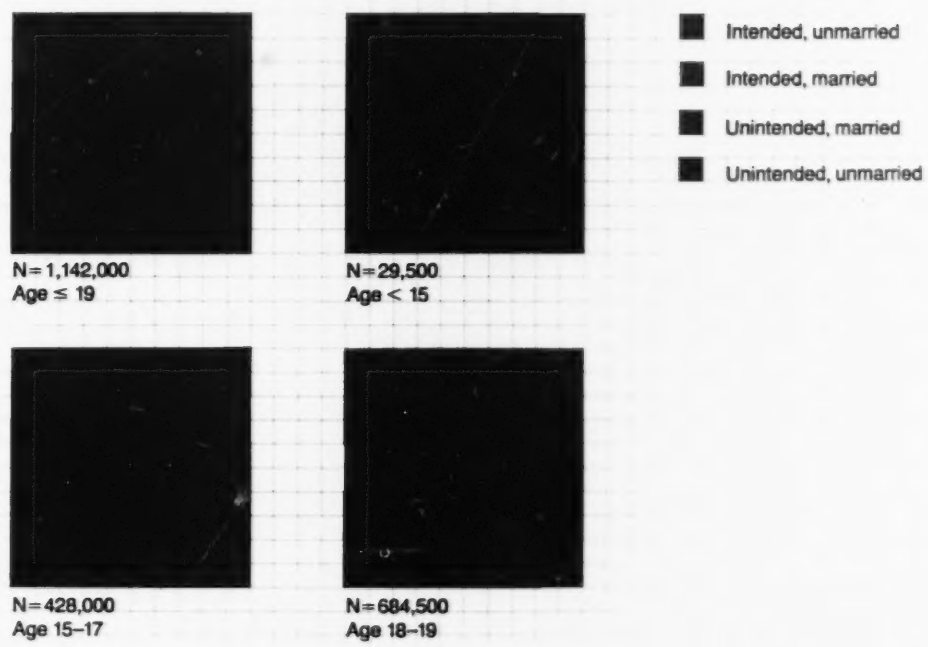
847,000 Teen Pregnancies Unintended—86% Among Unwed; 51% Among Married

Of the 1.1 million pregnancies that occurred among teenagers in 1978, 847,000 were unintended—86 percent of the 749,000 pregnancies among unmarried teens and 51 percent of the 394,000 pregnancies among those who were married. The younger the teenager, the more likely that her pregnancy was accidental. Virtually none of the 30,000 pregnant girls under age 15 had intended the pregnancy. Of the 428,000 15–17-year-olds who were pregnant, 87 percent conceived unintentionally. Even among the 685,000 pregnant 18–19-year-olds, 65 percent had not planned to conceive.

Of the 554,000 pregnancies that resulted in teenage births, 56 percent were unintended—66 percent of births to unmarried teenagers and 48 percent of births to those who were married.

Black teenagers were more likely than whites to have unplanned pregnancies and births: Eighty-two percent of pregnancies and 70 percent of births among blacks were unintended, compared to 71 percent of pregnancies and 49 percent of births among whites.

Figure 14.
Percentage distribution of pregnancies among U.S. women younger than 20, by pregnancy intention and marital status, according to age, 1978



Contraception Cuts 2nd Teen Pregnancies But 15% Conceive Again Within a Year

Increased and more regular use of contraceptives has sharply reduced repeat pregnancies among teenagers who have had a first out-of-wedlock conception. Among teenagers interviewed in 1976, 15 percent of those who had had a first premarital pregnancy conceived again within a year, compared to 22 percent of those interviewed in 1971. Within two years, 30 percent had a repeat pregnancy (compared to 50 percent in 1971). Among those whose first pregnancy had ended in a live birth, 17.5 percent had a subsequent pregnancy; while among those whose first pregnancy had been terminated by abortion, only 10 percent had a second pregnancy within a year. (This may be at least in part because contraceptive advice and services are more available to the unwed teenager who has an abortion than to one who gives birth.)

Seventeen percent of teenagers who remained unwed after the first conception had a second premarital pregnancy.

4 in 10 Young Girls Will Get Pregnant As Teens, 2 in 10 Will Give Birth

About 780,000 (39 percent) of the two million girls turning 14 this year can be expected to have at least one pregnancy while still in their teens; some 420,000 can be expected to give birth at least once and about 300,000 can be expected to have at least one abortion.

These projections are based on current behavior of U.S. teenagers. If sexual activity continues to increase—as it shows every sign of doing—the number of pregnancies can be expected to rise unless there is a considerable improvement in consistent and effective contraceptive use.

One in 5 Teens at Risk of Pregnancy; 2 in 5 Have O.W. Births, 1 in 3 Obtain Abortions

Of the 28.5 million sexually active, fertile women aged 14–44, five million, or 18 percent, are teenagers. Teenagers account for about the same proportion—17 percent—of the 3.3 million births that occurred in 1978. However, they represent 46 percent of the 543,000 out-of-wedlock births, and only 11 percent of the 2.8 million marital births. Teenagers obtained 31 percent of the 1.4 million abortions that occurred in that year. Therefore, the proportion of all pregnancies that occurred to teenagers (21 percent) is somewhat higher than the proportion of women exposed to the risk of pregnancy who are teenagers.

Figure 15.
Percentage of women aged 15–19 who had a second pregnancy within 12 months following a first premarital pregnancy, by whether the first pregnancy ended in a birth or an abortion; and percentage of those who remained unmarried who had a second premarital pregnancy, as of 1976

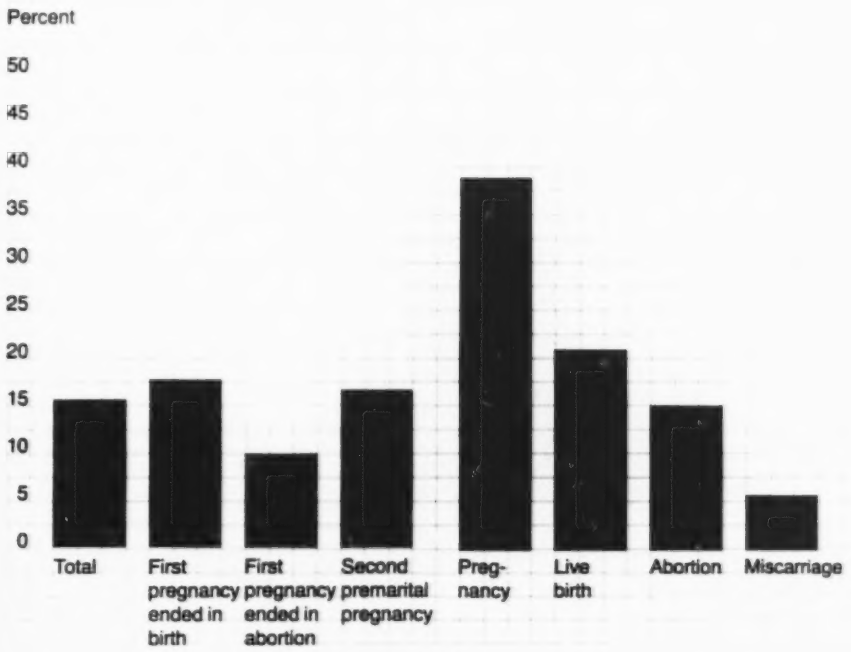
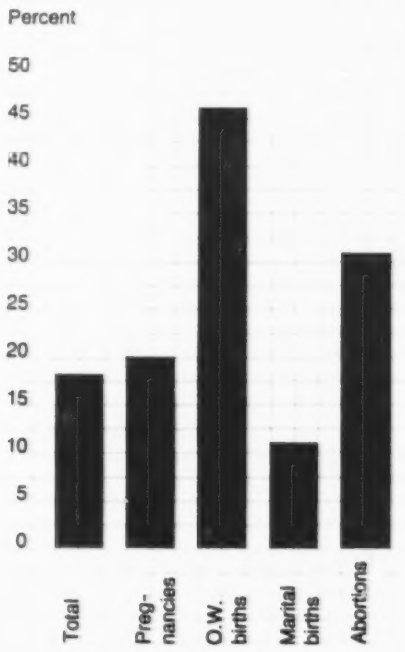


Figure 16.
Percentage of 14-year-old girls who can be expected to have at least one pregnancy, live birth, abortion or miscarriage before age 20

Figure 17.
Percentage of women exposed to the risk of pregnancy who are younger than 20, and percentage of all pregnancies, out-of-wedlock (O.W.) births, marital births and abortions that occurred among women younger than 20, 1978



SECTION 4

Adolescent Births

The number and rate of births declined during the 1970s for all teenagers except those under age 15. However, the decline has been less steep than that among women in their 20s. What is more, despite the decrease, the U.S. teenage birthrate is higher than those of all but a handful of developed countries—higher even than the birthrates in several developing countries.

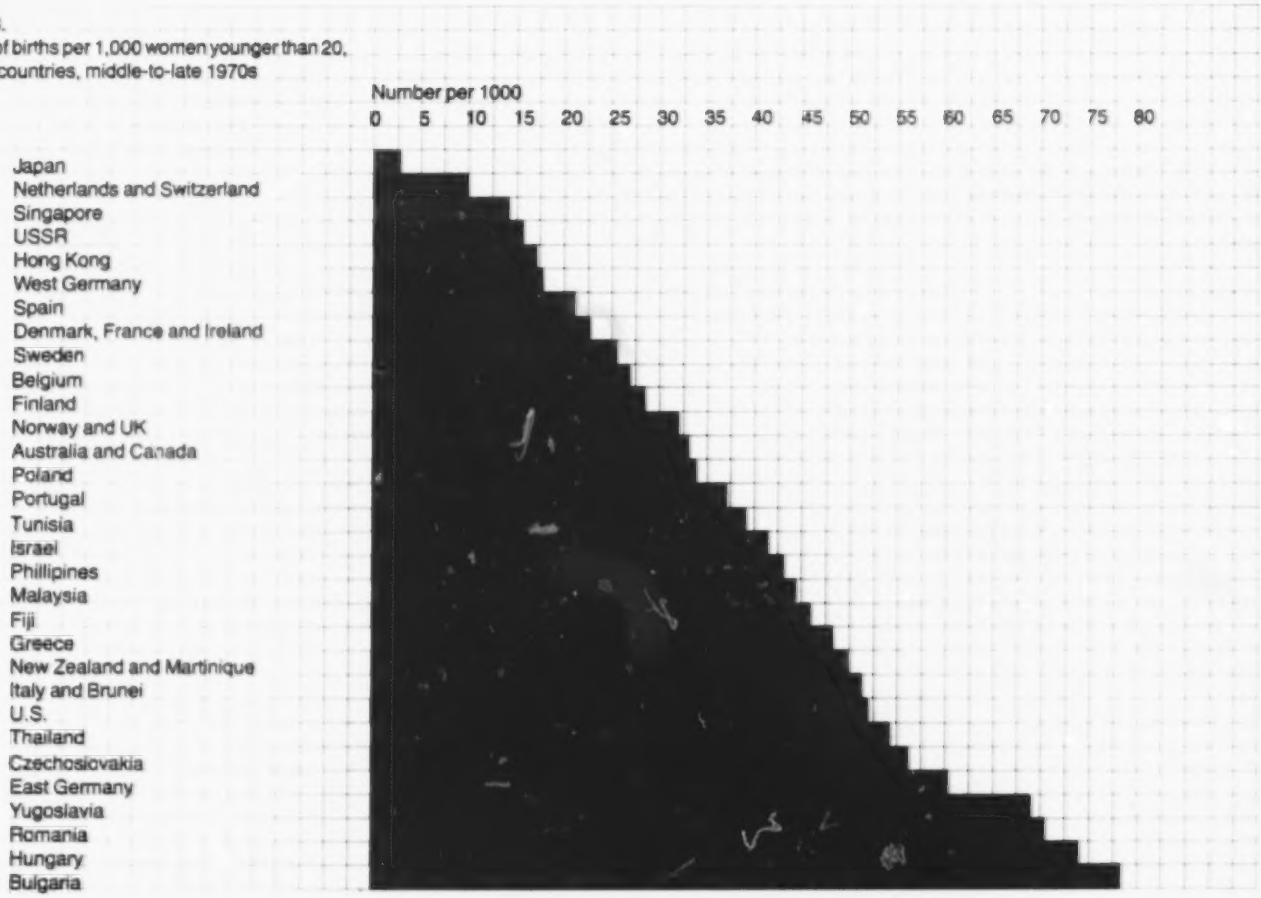
Although slowed because of the availability of legal abortion, the rise in the out-of-wedlock birthrate has continued among almost all groups of teenagers. The rise has been most steep among 15–17-year-old whites. The number of premaritally conceived births legitimated by marriage has been declining. Almost all unwed teenage mothers keep their children in the household with them.

All in all, 554,000 babies were born to teenagers in 1978, and 1.3 million small children were living with teenage mothers, half of whom were unmarried. An additional 1.6 million children under age five were living with mothers who were teenagers when they gave birth.

Teenage Birthrate in United States Is Among the World's Highest

About five percent of U.S. teenagers give birth each year. A higher proportion of adolescents become mothers in the United States than in any developed country, except for Czechoslovakia, East Germany, Yugoslavia, Romania, Hungary and Bulgaria. Japan's teenage birthrate is one-eighteenth as high; the Netherlands and Switzerland have rates just one-fifth as high as that of the United States. The U.S. rate is about three times higher than the Soviet Union's, and is about the same as that of Italy and Thailand. It is higher than the rate in such developing countries as the Philippines, Malaysia, Singapore and Tunisia.

Figure 18.
Number of births per 1,000 women younger than 20, selected countries, middle-to-late 1970s

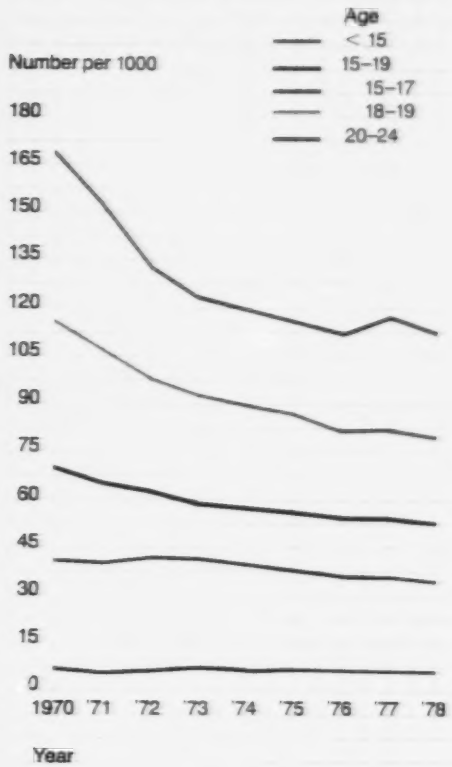


Teenage Birthrate Drops Much Less Sharply Than That of Women in their 20s

In 1978, three percent of 15–17-year-olds and eight percent of 18–19-year-olds gave birth. The U.S. teenage birthrate is relatively high, although it fell throughout the 1970s. It did not drop so steeply as the rate for women in their 20s, however. The younger the teenager, the smaller the birthrate decline: The rate for 20–24-year-olds fell by 33 percent between 1970 and 1978; for those aged 18–19, the decline was 29 percent; for 15–17-year-olds, it was 15 percent; and for girls under 15, there was no decline at all.

As might be expected, 78 percent of births to teenagers are first births. However, 18 percent are second births, and four percent are third or higher order births. The sooner a teenager gives birth after initiation of intercourse, the more likely she is to have subsequent births while still in her teens.

Figure 19.
Number of births per 1,000 women younger than 25, by age-group, 1970–1978



Teenage O.W. Birthrate Rising, But Increase Slowed by Abortion Use

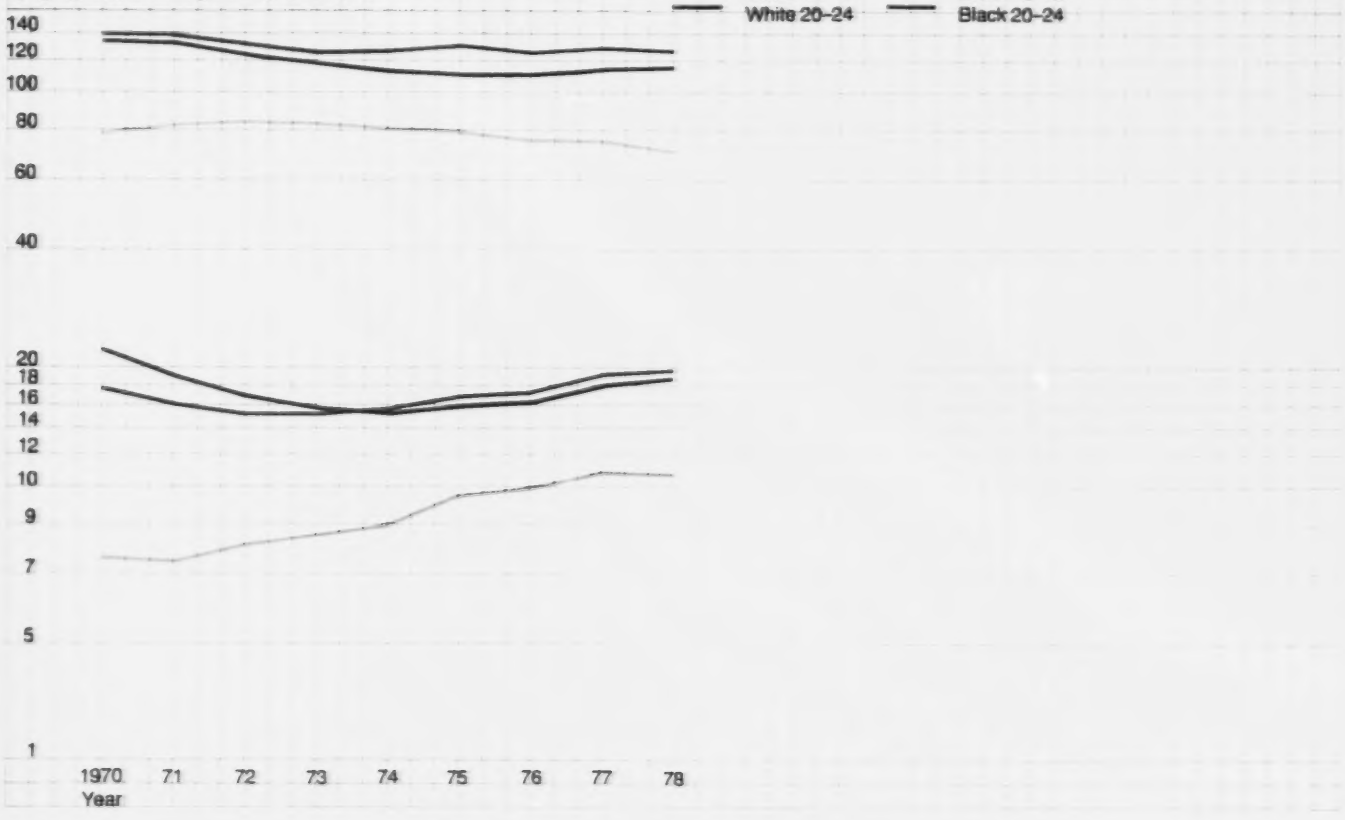
The rate of out-of-wedlock births to teenagers continued to rise over the 1970s, although at a much slower rate than it did in the 1960s (13 percent compared to 34 percent). Indeed, the liberalization of abortion laws in several large states in 1970, and abortion legalization nationwide in 1973, brought the historic increase in births to teenagers outside of marriage to a virtual halt in the first part of the decade; by the late 1970s, however, the rate again began to climb slowly, largely because fewer teenagers married to legitimate births.

Notably, the increase in the adolescent out-of-wedlock birthrate in the 1970s was confined to whites (a rise of 27 percent)—especially those aged 15–17, among whom there was a 40 percent rise. Rates among black teenagers actually declined in the 1970s by seven percent; among younger black teenagers, the decline was 10 percent, and it was continuous following the 1973 Supreme Court decisions legalizing abortion.

All in all, about 249,000 of the 544,000 out-of-wedlock births that occurred in 1978 were to women under age 20—about equally divided between 18–19-year-olds and those aged 17 and younger.

The out-of-wedlock birthrate among 20–24-year-olds declined more sharply than the teenage rate in the first half of the 1970s, but has been rising again almost as steeply since mid-decade.

Figure 20.
Number of out-of-wedlock births per 1,000 unmarried women aged 15–24, by age-group, according to race, 1970–1978



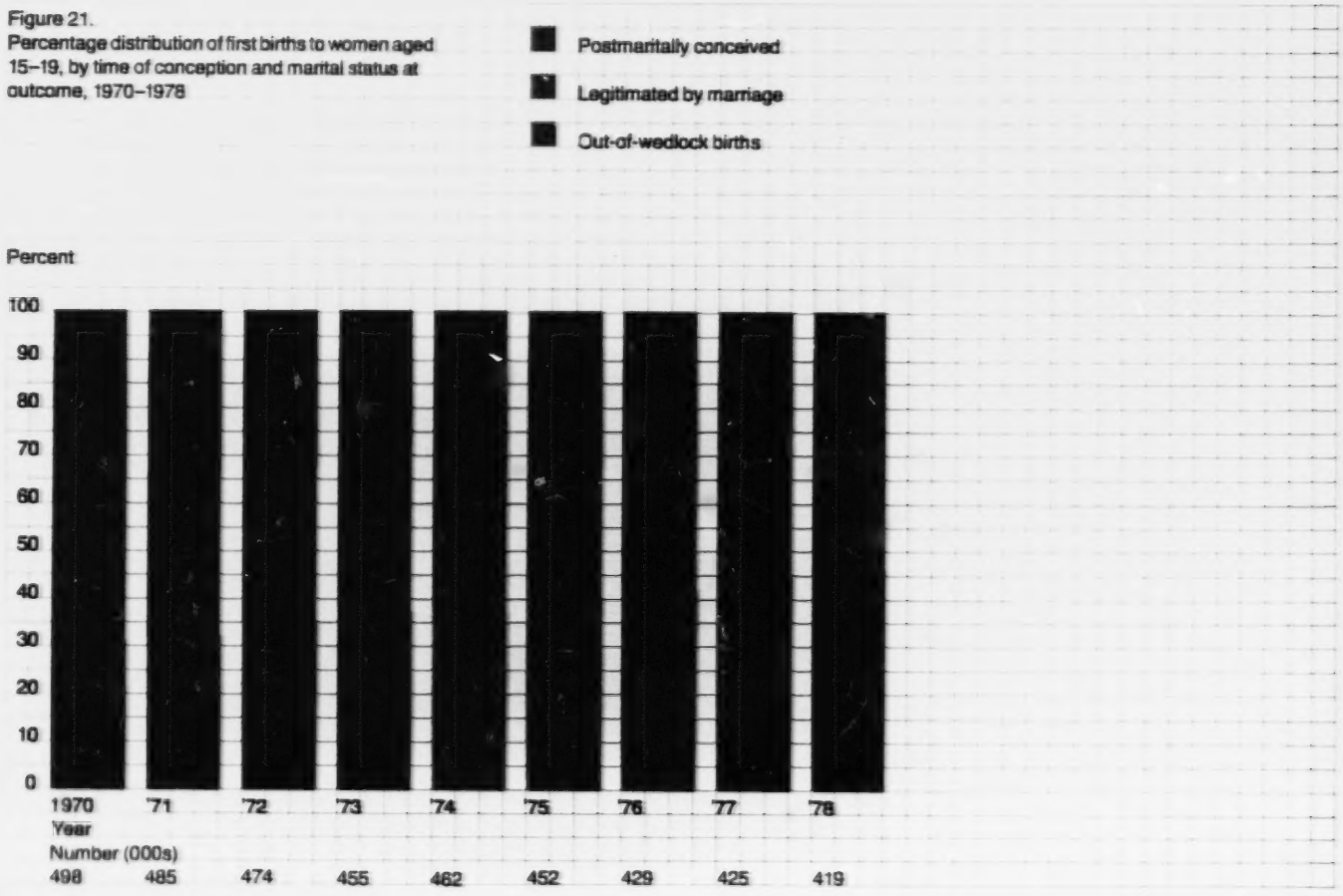
Teen Premarital Conceptions Rise; Fewer Legitimated by Marriage

While there was an increase in out-of-wedlock births among teenagers during the 1970s, there was a decline in the number of brides pregnant at marriage. There was an even sharper drop in the number of births conceived by teenagers following marriage. As a result, whereas 63 percent of first births to teenagers were the result of premarital conceptions in 1970, the proportion was 72 percent in 1978.

In 1970, 37 percent of first births to adolescents were the result of postmarital conceptions, 32 percent were from premarital conceptions delivered following marriage and 31 percent were delivered out of wedlock. By 1978, the picture had changed dramatically: Only 28 percent of first births had been conceived following marriage, 26 percent had been conceived premaritally but were delivered following marriage and 46 percent were out-of-wedlock births.

In 1978, as in 1970, close to half of all marital first births to teens were premaritally conceived.

Figure 21.
Percentage distribution of first births to women aged 15–19, by time of conception and marital status at outcome, 1970–1978



Only a Few Unwed Teen Mothers Give Up Children for Adoption or Care by Others

Although two-thirds of births to unmarried teenagers are unintended, unwed teenage mothers very rarely give up their babies for adoption or for care by friends or relatives. Ninety-six percent of unmarried teenage mothers—90 percent of white and virtually all of black mothers—keep their children with them (although in many cases, grandparents or other relatives help take care of the baby). In 1971, resort to adoption or care by others was more common: Eighty-seven percent of teen mothers kept their children—75 percent of white mothers and 94 percent of blacks. With legalization of abortion, many unwed teenagers choose to terminate unwanted pregnancies by abortion rather than to bear children that they would have to give up for adoption or for care by friends or relatives. If they do not have abortions, most keep their babies.

1.3 Million Children Now Living With 1.1 Million Teenage Mothers

Despite the decline in adolescent childbearing, there are about 1.3 million children now living with 1.1 million teenage mothers. More than half of these children are living with unmarried mothers. Two-thirds were born to mothers aged 17 or younger. There are an additional 1.6 million children under age five who were born to teenage mothers—1.2 million of them were born out of wedlock, and 635,000 were born to unwed mothers aged 17 or younger.

These figures give some idea of the magnitude of the problems involving teenage mothers and their children.

Figure 22.
Percentage distribution of out-of-wedlock births resulting from first conceptions to women aged 15–19 in 1976, by disposition, according to race

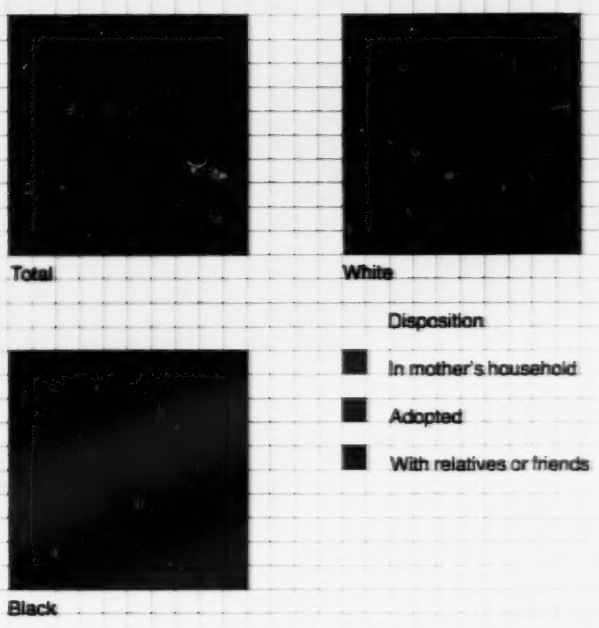
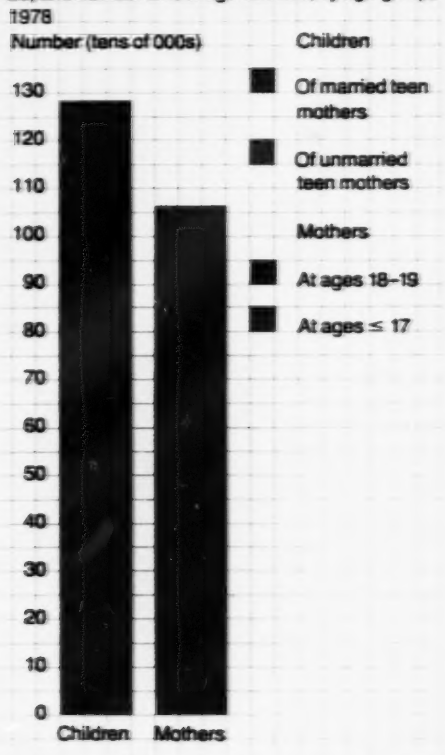


Figure 23.
Number of children living with mothers younger than 20, and number of teenage mothers, by age-group, 1978



SECTION 7

Family Planning Services And Contraceptive Research

Most teenagers and adults approve of making contraceptives available to teenagers, and most parents favor family planning clinics providing birth control services to their children. In fact, the number of teenagers attending family planning clinics grew from 214,000 to 1.5 million between 1969 and 1978. The clinics have had the expected result of improving the quality and consistency of contraceptive use among teenagers, and have been credited with preventing an estimated 689,000 unintended births, and probably a higher number of abortions, among teenagers.

However, most teenagers are sexually active for many months before ever seeking birth control help from a family planning clinic or physician. Very few come to a clinic in anticipation of initiating sexual intercourse, and many come because they fear—often correctly—that they are pregnant. The major reason teenagers give for the delay is concern that their parents will find out about the visit. (About one-fifth of clinics say that they require parental consent or notification for at least some teenage patients.) More than half of teenage patients have told their parents about their clinic visit, and only about one-quarter would not come if the clinic required parental notification. But most of these would continue to be sexually active, using less effective methods or no contraceptives and many thousands would get pregnant as a result.

Nearly as many teenagers as are attending clinics are getting services from private physicians. More than one million are using condoms or spermicides obtained from drugstores, or are depending on ineffective folk methods. More than three-quarters of a million teenagers do not want to get pregnant but are having intercourse and using no birth control method.

Although many teenagers choose the pill, a highly effective method, it is less than ideal for young people for whom sex is occasional and episodic. More appropriate contraceptive methods are needed, such as a safe morning-after pill or a once-a-month pill. But shrinking research dollars make it highly unlikely that such a method will be marketed before the next century.

SECTION 5

Consequences of Teenage Childbearing

The health, social and economic consequences of teenage pregnancy are almost all adverse. Pregnancies that end in abortion or miscarriage are, at the least, upsetting and sometimes traumatic to the pregnant woman. They also involve some health risks to the teenager (although abortions before the 16th week of pregnancy are less dangerous than childbirth). Those pregnancies that result in births, however—most of which are unintended—have the most obvious negative consequences and are of most concern.

Babies born to teenage mothers are much more likely to die in the first year of life than those born to mothers over age 20. Maternal mortality and morbidity, and the risk of having a low-birth-weight infant, are also considerably greater among teenage mothers.

The most far-reaching consequence of teenage childbearing is the truncation of education among the young parents, and the resulting limitation of opportunities to gain skills needed to compete in society. Largely because of educational deficits, teenage parents are frequently unable to get decent jobs, and their family incomes tend to be much lower than those earned by other families.

The high probability that a teenage mother will bring up her child in a home with no father present is another reason her family income is so low. Even if they do marry, teenage parents are far more likely to become divorced or separated than are those who delay childbearing, and their babies are far more likely to spend a large part of their childhood in one-parent households. Alone, with small children, little education and few skills, it is small wonder that many teenage mothers find themselves on welfare or living below the officially designated poverty level. What income they have needs to be stretched to feed more young mouths, since teenage mothers have more births and more unintended births in the course of their reproductive lives than do those who delay childbearing until their 20s.

Living in poverty, lacking education and opportunity and being brought up in a one-parent home hurts the children of teenage parents, too. Such children are likely to have lower IQ and achievement scores than others, and are more likely to repeat school grades than other children. When they grow up, they are more likely than others to become teenage parents themselves.

Unwed teenage mothers are more likely to complete their education, get decent jobs and avoid dependence on welfare if they live with their parents than if they live alone.

Infant Death Risk Twice as High for Teen Mothers as for Mothers in Their 20s

Data from New York State for 1974–1978 indicate that babies born to teenage mothers are far more likely to die in the first year of life than those born to mothers over age 20. Their risk of death is nearly two times greater than that of babies born to mothers in their 20s, and is greater than that of infants born to mothers aged 40 or older—a high-risk age-group.

Maternal mortality also appears to be higher among teenage mothers, especially young adolescent mothers: In 1977–1978, the maternal death rate among mothers under age 15 was 18 per 100,000 live births—two and one-half times the rate among mothers aged 20–24 (7.1). Nonfatal maternal complications were considerably lower in 1975–1978 than in 1961–1969 for all age-groups, but were still higher for teenage mothers than for others: Teenage mothers were 15 percent more likely to suffer from toxemia, 92 percent more likely to have anemia and 23 percent more likely to suffer from complications attendant upon a premature birth than were mothers who gave birth at ages 20–24.

The risks are much greater for those who are poor and black, but differentials by age at birth still persist.

Mothers 15 and Younger 2 Times More Likely to Have Low-Birth-Weight Babies

Teenage mothers are far more likely than those who delay childbearing until their 20s to have babies that are premature or of low birth weight (less than 5.5 pounds). Low birth weight is a major cause of infant mortality, as well as a host of serious childhood illnesses, birth injuries and neurological defects, including mental retardation.

Improved prenatal care has reduced prematurity and low-birth-weight rates among all age-groups, but mothers aged 15 and younger are still two times more likely to have low-birth-weight babies than are those aged 20–24. Among all teenagers, the risk is about 39 percent higher. The risk declines with increasing age of the young mother, but even mothers aged 19 have rates 27 percent higher than those who wait to give birth until they are in their early 20s. Low-birth-weight rates among black babies continue to be much higher than those among whites whatever the age of the mother, in part because black women obtain prenatal care much later.

Figure 24.
Number of infant deaths per 1,000 live births, by age of mother, New York State, 1974–1978

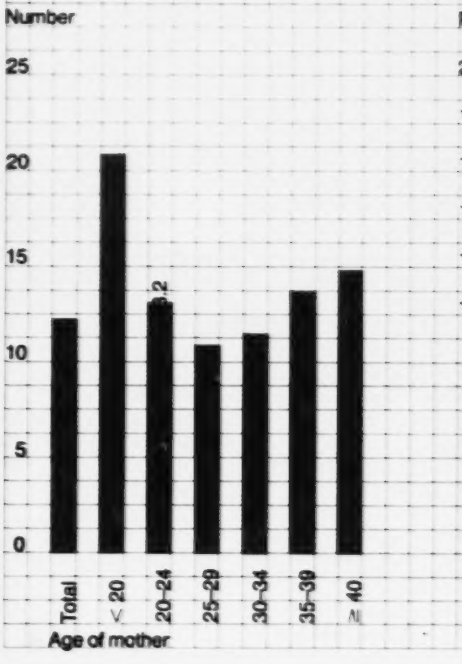
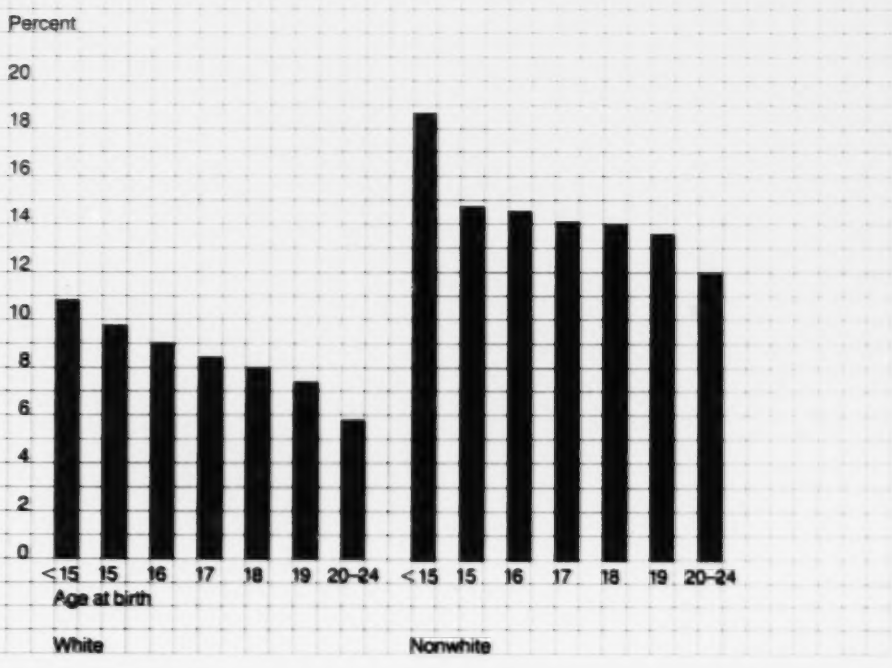


Figure 25.
Percentage of babies of low birth weight (less than 2,500 grams), by age of mother, according to race, 1978



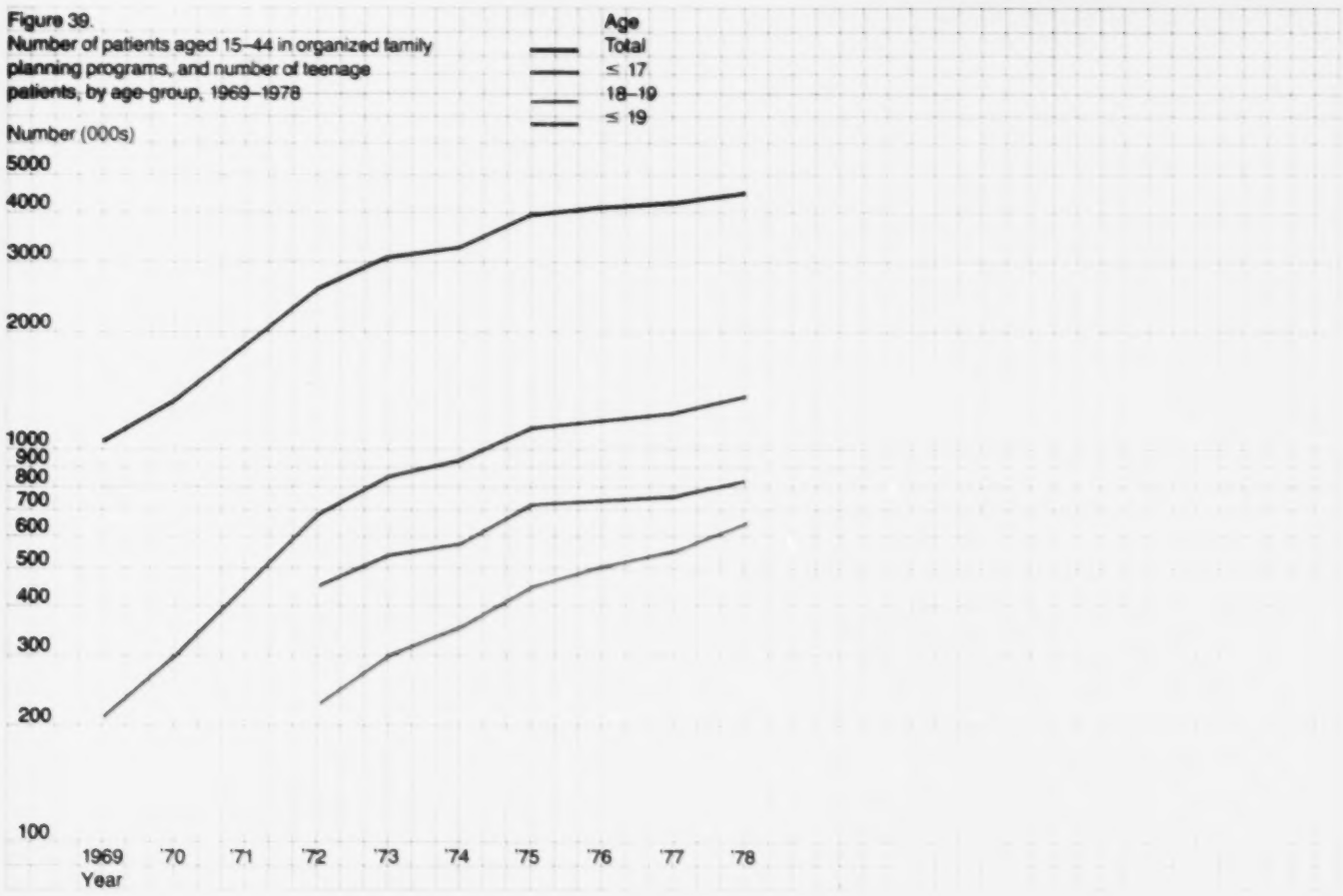
7-fold Increase in Teen Clinic Patients in Decade; Total Patient Increase 4-fold

Nearly one and one-half million teenagers attended family planning clinics in 1978—one-third of the 4.5 million clinic patients. Nine years before, there were only 214,000 adolescent patients, and they represented just one-fifth of the total.

Younger teenage patients account for most of the increase. Between 1972 and 1978, the total number of family planning clinic patients and the number aged 18 or 19 grew by about 75 percent, but the number of patients under age 17 tripled.

All of the 5,000 organized family planning facilities serve at least some teenage patients. About 40 percent are served by health departments; 30 percent, by Planned Parenthood affiliates; 19 percent, by such other agencies as women's health centers and neighborhood health clinics; and 11 percent, by hospitals.

Figure 39.
Number of patients aged 15–44 in organized family planning programs, and number of teenage patients, by age-group, 1969–1978



Teen Childbearing Frustrates Educational Opportunities, Preparation for Careers

Many teenage parents finish high school; some even get to college. But the majority of them, especially of young teenage mothers, never obtain even a high school diploma.

The devastating effect of early childbearing on educational opportunity is not simply the result of poverty, low aptitude or lack of interest in learning. A national study matched samples of young people for race, socioeconomic status, academic aptitude and achievement and educational expectations at age 15. It found that among these matched samples, when reinterviewed at age 29, mothers who had given birth before they were 18 were only half as likely to have graduated from high school as those who postponed childbearing until after they turned 20.

For young fathers in the matched samples, the effect, as might be expected, was less dramatic, but still substantial: Those who became fathers before age 18 were two-fifths less likely to have graduated from high school than those who waited.

The net effect of childbearing at ages 18–19 on high school graduation is significant, but not nearly so great as childbearing at younger ages. It has a very large effect, however, on completing college. By age 29, women who delayed childbearing until their 20s were 4–5 times more likely to have completed college than those who became mothers in their teens. By age 29, young men who became fathers in their teens were only half as likely to have completed college as those who put off fatherhood until their early 20s.

Studies show that children of teenage parents also suffer educational and cognitive deficits: They tend to have lower IQ and achievement scores than the children of those who delayed childbearing, and are more likely to repeat at least one school grade.

Income of Young Teen Mothers Half That Of Those Who First Gave Birth in Their 20s

Teenage parents are more likely than those who delay childbearing to have low-status, low-paying jobs or to be unemployed. The mean family income in 1975 of white women who gave birth at or before age 16 was $7,550, about half of the $13,900 earned by families where the mother delayed birth until her middle-to-late 20s. The younger the mother at childbirth, the lower her annual family income.

Looked at in another way, 54 percent of 24-year-old women who had given birth at age 17 or younger were classified as being of low socioeconomic status, compared to 33 percent of those who had given birth between ages 21 and 23 and 15 percent of those still childless.

Poor education is one of the major factors keeping teenage mothers' incomes low. Another factor is the relatively high probability that teenage mothers will bring up their child in a home where there is no breadwinning father present.

Figure 26.
Percentages of mothers and fathers, in samples matched for race, socioeconomic status, academic aptitude, achievement and educational expectations at age 15, who received a high school diploma and completed college, by age of parent at birth of first child

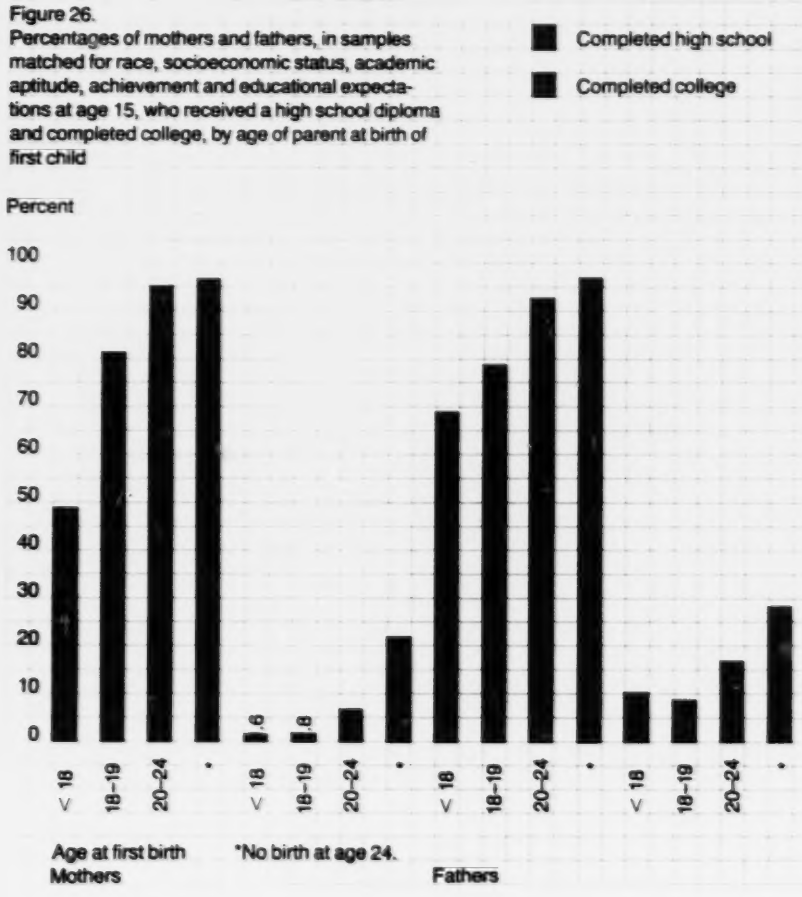
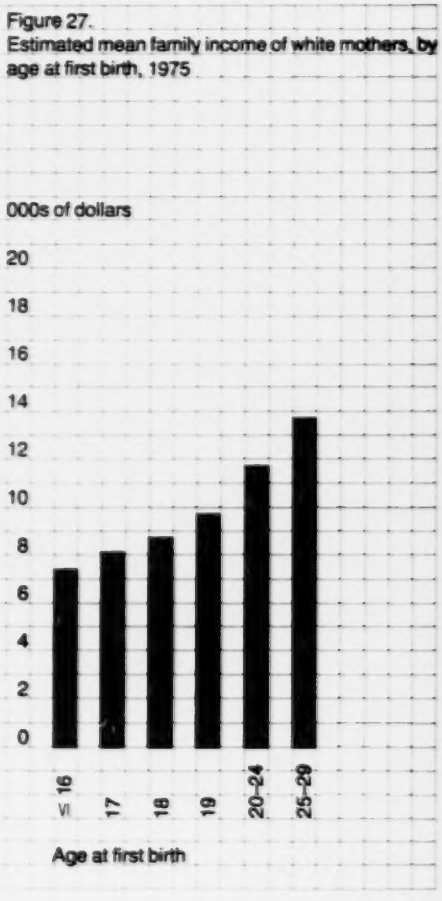


Figure 27.
Estimated mean family income of white mothers, by age at first birth, 1975



Marriage Disruption 3 Times More Likely For Young Teens Than Later Childbearers

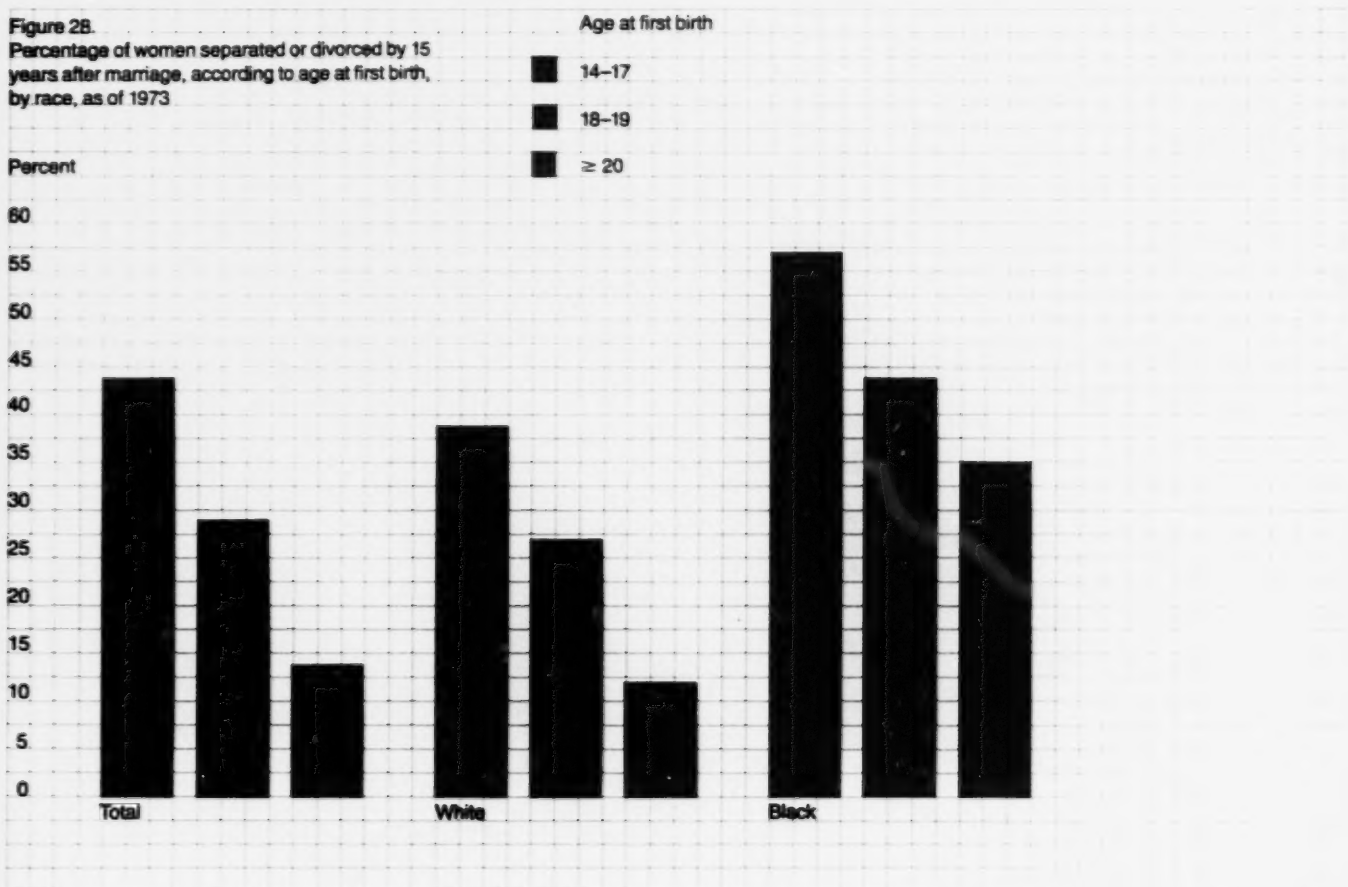
If they marry, teenage parents are far more likely to separate or divorce than couples who postpone childbearing until their 20s. The trend is evident among women of all races, but is more pronounced among whites than among blacks.

Forty-four percent of women who gave birth at ages 14–17 are separated or divorced within 15 years, three times the proportion among women who did not begin childbearing until age 20 or later. Marriage disruption is two times more likely among those who become parents at ages 18–19 than among those who wait until their 20s.

As a result of this pattern, by age eight, 70 percent of children first-born to women at age 17 or younger have spent part of their childhood in a single-parent household. This compares to 41 percent of the children first-born to women at ages 18–19, and about 25 percent of children first-born to women in their 20s.

Young mothers who do not live with the child's father are far less likely to receive child-support payments than are older mothers: More than one-quarter of all mothers who are not living with their child's father receive child-support payments, compared to only one in 10 such mothers aged 14–24. For the small number of young mothers who do receive financial help from the father, the support payments are generally small, averaging only $1,388 a year.

Figure 28.
Percentage of women separated or divorced by 15 years after marriage, according to age at first birth, by race, as of 1973



$4.7 Billion in AFDC Payments to Families Where Mother Gave Birth in Her Teens

Many teenage mothers with small children to take care of, few skills, little education and no husband in the home must become dependent on public welfare for support. In 1975, about half of the $9.4 billion invested in the federal Aid to Families with Dependent Children (AFDC) program went to families in which the woman had given birth as a teenager. Six out of 10 women in families receiving AFDC payments had given birth as teenagers, compared to just about one-third of women in families not receiving such payments.

About one-fourth of teenage mothers are currently receiving AFDC payments.

Figure 29.
Percentage distributions of women in AFDC households and non-AFDC households, by whether they gave birth before age 20, and percentage distribution of $9.4 billion in AFDC payments, by whether recipients gave birth before age 20, 1975

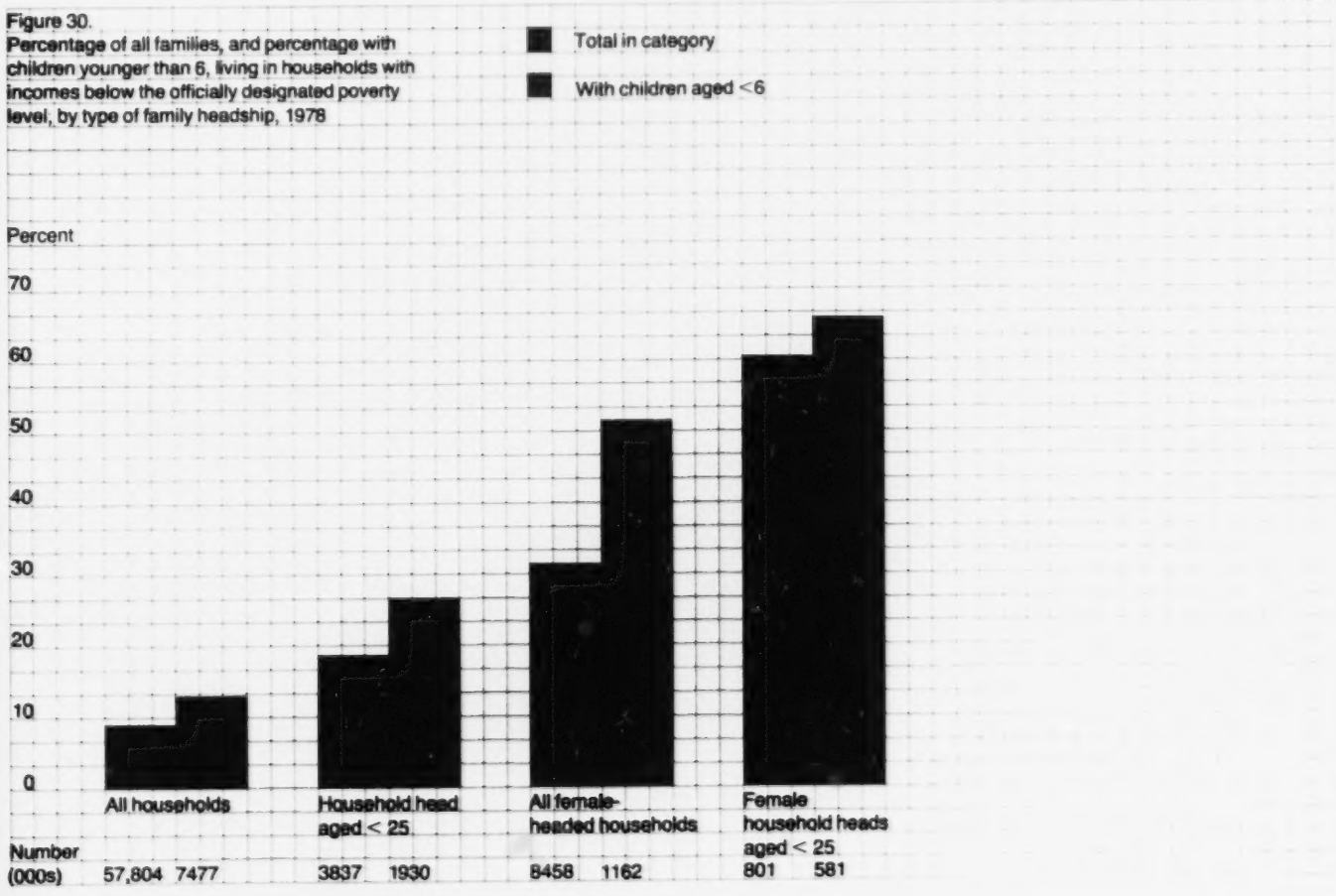
Women in AFDC households
Women in non-AFDC households
$9.4 billion in AFDC payments
Gave birth before age 20
Did not give birth before age 20

Families Headed by Young Mothers 7 Times as Likely as Others to Be Poor

There are nearly 600,000 families with children five years old or younger headed by mothers aged 14–25. Two-thirds of these families are living below the officially designated poverty level ($6,682 for a nonfarm family of four). This is five times the proportion of all families with such young children living in poverty (13 percent), and seven times the proportion of all families living in poverty (9 percent).

Indeed, the median annual income of families headed by women under age 25 is $3,953—well below the official poverty level. Such families have incomes only about one-fifth as high as that of all families and three-tenths as high as that of young husband-wife families.

Figure 30.
Percentage of all families, and percentage with children younger than 6, living in households with incomes below the officially designated poverty level, by type of family headship, 1978



Young Teenage Mothers Have 50% More Births Than Later Childbearers

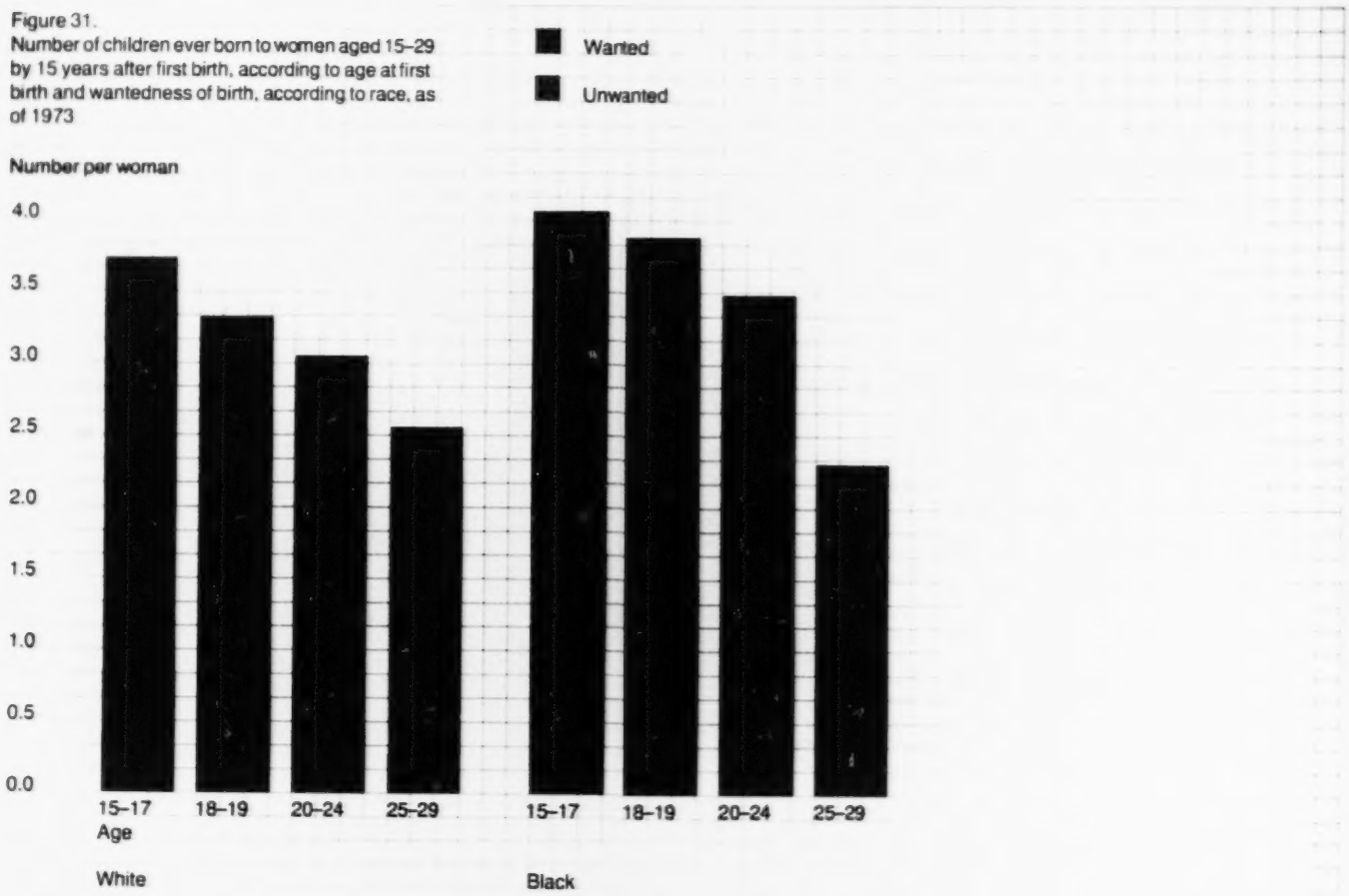
Women who gave birth as teenagers not only have lower incomes than other women, but generally have to stretch that income to feed more mouths.

White women who first gave birth at ages 15–17 have about 46 percent more children than those who waited to become parents until their middle-to-late 20s; those who gave birth at ages 18–19 have 30 percent more children.

Survey research also provides information about birth intentions. The number and proportion of all births that are unintended rise sharply with earlier age at childbearing—21–23 percent of all births to white women who became mothers as teenagers were unintended, compared to 10 percent of births to those who waited until their middle-to-late 20s.

The average mother who gave birth at ages 15–17 has had one unintended birth, while only one in four women who started childbearing at ages 25–29 has had an unintended birth. The same trends are seen among blacks as among whites, but the effects of early childbearing for total and unintended births are even more extensive for black women.

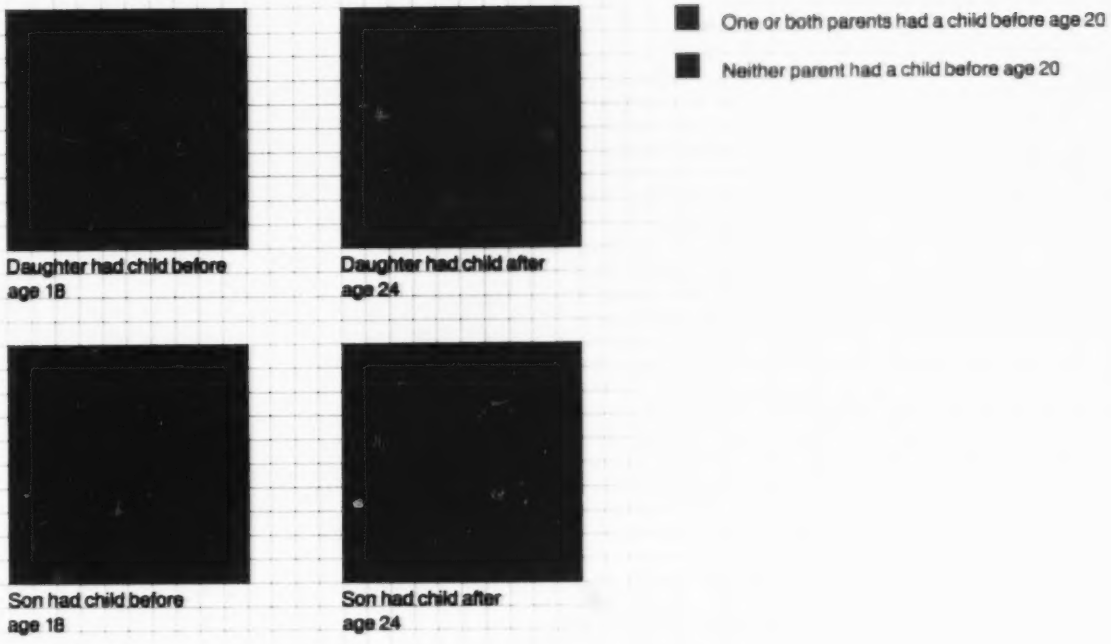
Figure 31.
Number of children ever born to women aged 15–29 by 15 years after first birth, according to age at first birth and wantedness of birth, according to race, as of 1973



Teen Mothers More Likely to Have Had A Teen Parent Than Later Childbearers

Of those women who became mothers at age 17 or younger, 22 percent had at least one parent who had had a child as a teenager—more than two times the proportion of women who delay childbearing to age 25 or later. Forty-three percent of comparable young fathers had a teenage parent—nearly five times the proportion of young men who did not become parents before age 25. All in all, about 20 percent of teenage fathers and 15 percent of teenage mothers had a teenage parent—about half again the proportion of those who delayed parenthood until after age 20 (14 percent and 10 percent, respectively). The younger the mother at birth, the more likely she is to have had a teenage parent. In one study, 82 percent of girls who became mothers at age 15 or younger had mothers who first gave birth as teenagers.

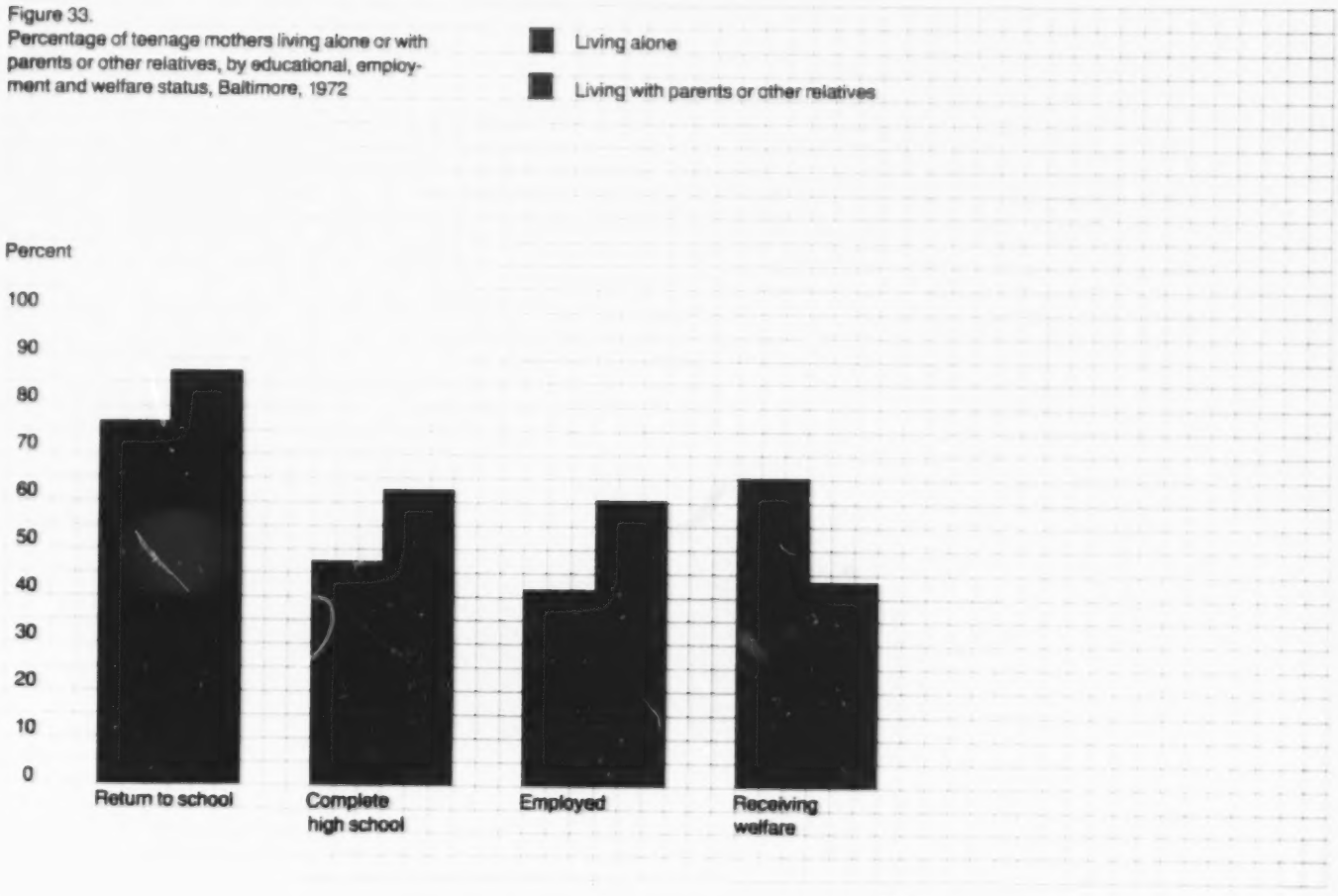
Figure 32.
Percentage distributions of women and men who first had a child before age 18 and who delayed childbearing to age 25 or older, according to age at which their parents first gave birth


One or both parents had a child before age 20
Neither parent had a child before age 20
Daughter had child before age 18
Daughter had child after age 24
Son had child before age 18
Son had child after age 24

Parental Support May Ease Some Adverse Consequences of Teenage Childbearing

Some of the adverse consequences of early childbearing are mitigated when the teenage mother and her child get parental assistance. For example, of those unwed mothers who lived with parents or relatives, 87 percent remained in school following childbirth, compared to 76 percent of those who lived alone; 62 percent were graduated from high school, compared to 47 percent of those who lived alone; 60 percent got jobs, compared to just 41 percent of those who lived alone; and only 43 percent received welfare assistance, compared to 65 percent of the young mothers who lived away from their parents. When grandparents or the child's father helped the teenager care for her baby, the child's cognitive development was found to be superior to that of children brought up by a young mother alone.

Figure 33.
Percentage of teenage mothers living alone or with parents or other relatives, by educational, employment and welfare status, Baltimore, 1972



SECTION 6

Sex Education

The overwhelming majority of Americans favor sex education in the schools, but only a handful of states require or even encourage it; fewer still encourage teaching about birth control or abortion. Most states leave the question of sex education up to the local school boards. Only a minority, however, provide such instruction. When sex education is offered, the course content is often so watered down that teenagers do not learn even such basic facts as the time of month when pregnancy is most likely to occur.

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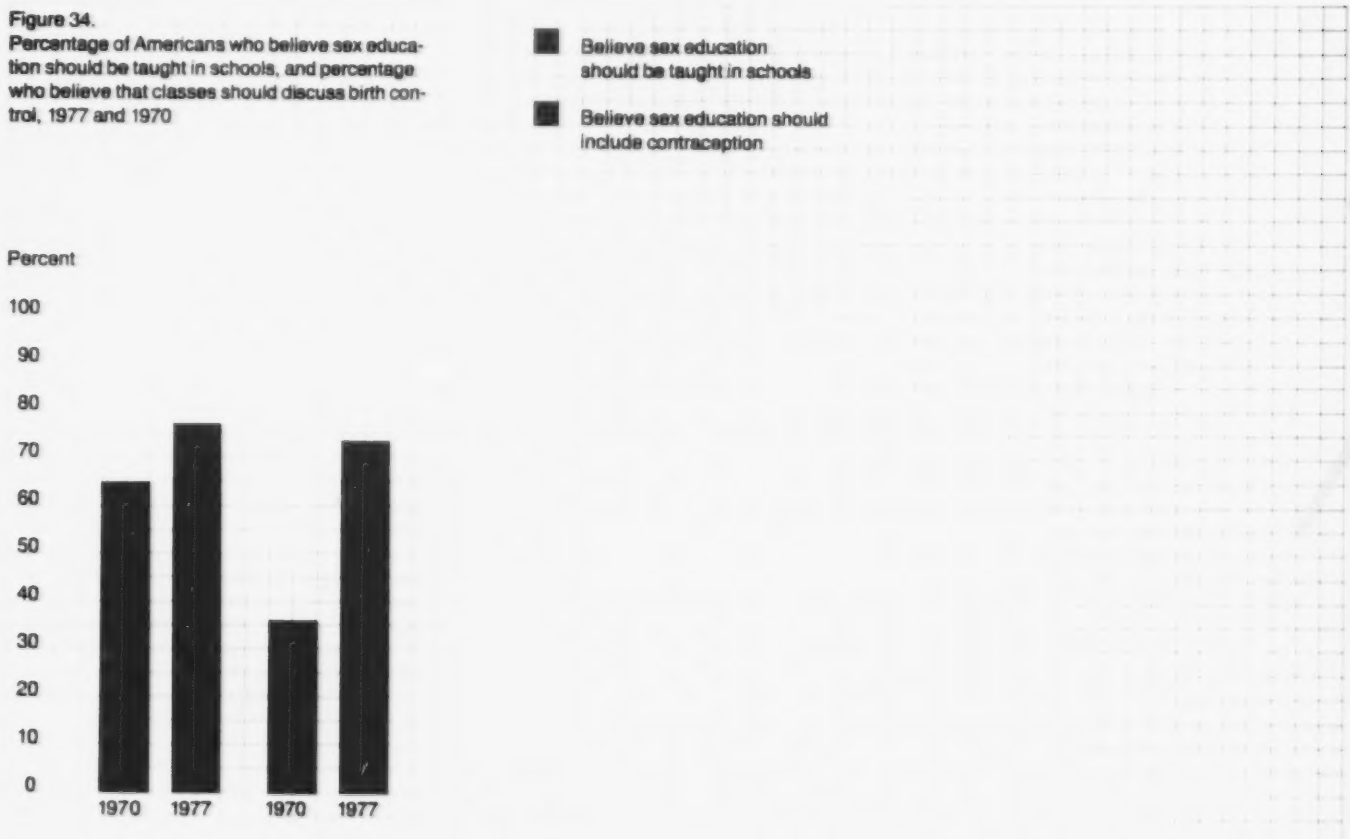
8 in 10 Americans Favor Sex Education; 7 in 10 Approve Birth Control Instruction

Eight out of 10 Americans believe that sex education should be taught in the schools, and seven out of 10 believe that such courses should include information about contraception. At the beginning of the decade, only two-thirds of Americans favored sex education, and only one-third thought that the schools should teach anything about birth control. The levels of approval of sex education and classroom discussion of contraception are identical for Catholics and Protestants.

Nine out of 10 parents of teenagers (and the same proportion of teenagers themselves) believe that young people should be educated about birth control and sexuality. Most teenagers, however, and the great majority of parents, do not believe that the responsibility for such education should be left to the schools alone—or even primarily—but should involve the parents.

Eight out of 10 parents favor talking about birth control and six in 10 favor discussing abortion with their daughters. This compares to six in 10 who would discuss birth control and five in 10 who would talk about abortion with their sons. Many parents, although willing, are unable to provide accurate information to teenagers about sexuality, reproduction and contraception. In one study, only 45 percent of mothers knew the time of month when a woman was most likely to get pregnant, and 41 percent knew how long a man's sperm can live inside a woman after intercourse; only 18 percent realized that a woman can get pregnant up to 48 hours after ovulation. A recent government-sponsored study found that 98 percent of parents reported needing help in talking to their teenage children about sex.

Figure 34.
Percentage of Americans who believe sex education should be taught in schools, and percentage who believe that classes should discuss birth control, 1977 and 1970



10 States, D.C., Require or Encourage Sex Education in the Schools

Despite the overwhelming approval of birth control and sex education in the schools, only three states (Kentucky, Maryland and New Jersey) and the District of Columbia require sex education. Only seven additional states even encourage it. Just 4.4 million of the 21 million junior and senior high school students in the United States live in these states.

Six states and the District of Columbia (with 3.1 million students) encourage the schools to teach their pupils about birth control, while three states (with 1.2 million pupils) discourage such instruction.

Discussion of abortion in the schools is encouraged by only one state (Illinois) and the District (with a total of 996,000 students), while three states (with 1.6 million students) discourage it.

Twelve states and the District of Columbia (with 6.2 million students) require that parents consent to their children's attendance at sex education classes or that parents may withdraw their children from such classes.

Nineteen of the states have no policy concerning school instruction in sexuality, reproduction, contraception or abortion, while 21 states have policies that explicitly leave such discussion up to the local school districts. These 40 states have about 16.2 million junior and senior high school students, four-fifths of the total.

Figure 35.
Policies on sex education, and on instruction in contraception and abortion, United States, 1978

- ■ Requires schools to offer family life and sex education
- ■ Encourages schools to offer family life and sex education
- ■ Leaves the decision to offer family life and sex education to local jurisdictions
- ■ Has no policy dealing expressly with sex education

A Encourages the discussion of abortion

A_d Discourages the discussion of abortion

B Encourages the discussion of birth control

B_d Discourages the discussion of birth control

C Requires parental consent prior to student's participation in family life and sex education class; or provides that student can be excused from such a class at the request of parents

Note: Although Kentucky has no policy on sex education, it requires that such instruction be offered as part of mandated health education.

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Only 4 in 10 Teens Get Sex Education; Only 3 in 10 Learn About Contraception

Although most local school districts are free to offer sex education and birth control instruction if they wish, only a minority do so.

A recent Gallup Youth Survey found that only 43 percent of male and female students aged 13–18 report having had *any* kind of sex education instruction in school, ranging from 55 percent of students from the West to just 30 percent of those from the South. Only 31 percent of students say that they were taught about contraception. In other words, of the 21 million young people of junior and senior high school age, nine million have had some kind of sex education in school and 6.5 million of these have had courses that included instruction in contraception.

Female students appear to fare somewhat better than males, especially if they are older: Two-thirds of 15–19-year-old women say that they had some sort of sex education in school, and a little under half say that they had instruction about birth control methods. Nine out of 10 who received sex education say that they were taught about VD, and almost all of them say that they received instruction about the menstrual cycle.

A 1978 survey of high school principals by the National Institute of Education found that only 36 percent of high schools have a separate sex education course. In Maryland, which has mandated sex education since 1973, only about one-quarter of students take the sex education courses that are offered. Thus, fewer than one in 10 high school students may actually be taking a separate course on sex education. Of course, many more receive some instruction on sexuality and reproduction in general health and biology courses.

Fewer Than 4 in 10 Teens Know Time Of Month When Pregnancy Is Likeliest

We have seen that the major reason given by teenage women for nonuse of contraception is their belief that they were having intercourse at a time of the month when conception was impossible. But only 37 percent of women aged 15–17 and 49 percent of those aged 18–19 know the time of greatest risk (about two weeks before menstruation). The fact that so many are mistaken about this important fact contributes to the high pregnancy rate among teenagers, especially younger ones. (As we saw in the discussion of Figure 34, teenagers' mothers are no better informed than their daughters.)

Teenagers who have had sex education are only somewhat more likely to know the time of month when they are at greatest risk. Forty-five percent of 15–19-year-old women who have had sex education, and 32 percent of those who have not, are correctly informed about the time of greatest risk. Although younger adolescents are only three-quarters as likely as older teens to know the time of greatest risk, their knowledge is improved by sex education courses much more than is the knowledge of older teenagers.

Figure 36.
Percentage of never-married females aged 15–19 in 1976, and of male and female students aged 13–18 in 1978, who have ever had formal instruction in sex education, by content of course

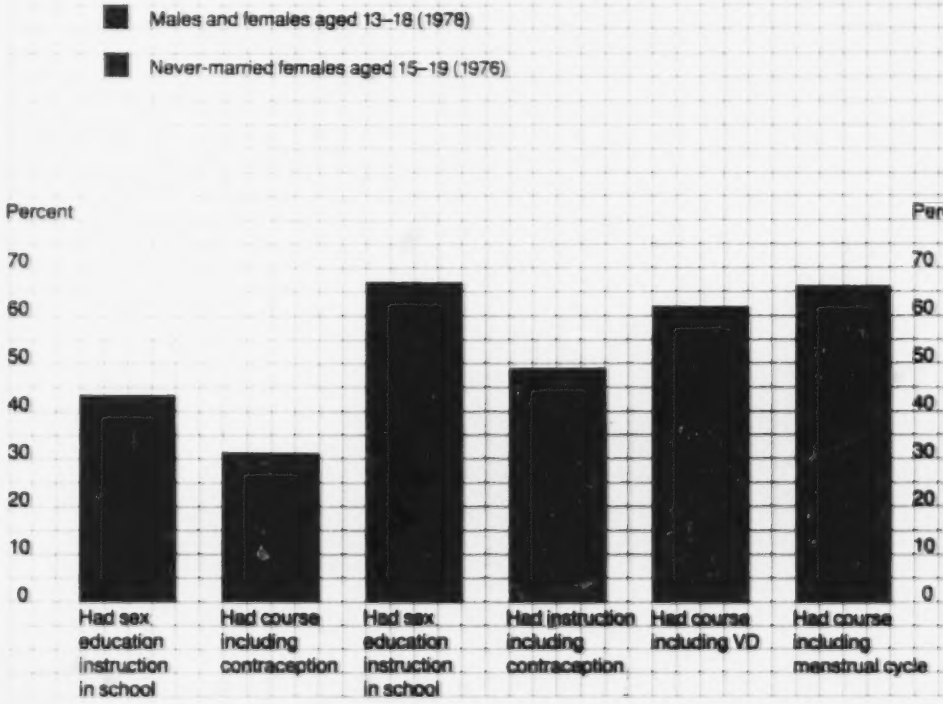
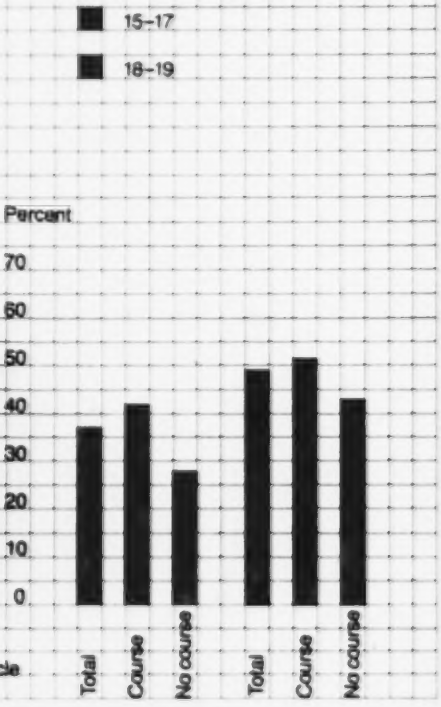


Figure 37.
Percentage of never-married women aged 15–19 who correctly perceived time of greatest risk, by whether they have had a sex education course



Six in 10 Teens and Adults Favor Making Contraceptives Available to Adolescents

Fifty-nine percent of teenagers and 56 percent of adults favor making contraceptives available to male and female adolescents. There is no difference between Catholics and Protestants in the level of support.

A government-sponsored survey of two groups of parents—one group whose teenage children were attending family planning clinics and one whose children were not—found that nine in 10 of each group believed that family planning clinics should provide services to teenagers. However, nearly half said that the parents should be involved in a teenager's decision to attend a clinic.

Figure 38.
Percentages of teenagers and adults who believe contraceptives should be made available to adolescents, 1978

More Than 8 in 10 Teen Clinic Patients Choose the Pill, IUD or Diaphragm

Half of teenagers who first come to a family planning clinic have never before used any method of contraception; one-third have previously used a medically prescribed method, mainly the pill. After clinic enrollment, six out of seven new teenage patients use the most effective, medically prescribed methods.

In 1978, 75 percent of new and continuing teenage patients were using the pill at their last clinic visit; four percent had IUDs inserted; four percent used the diaphragm; five percent employed foam; three percent said they depended on their male partners (condom or withdrawal); and one percent used other methods. The remainder either did not practice contraception because they were found to be pregnant or came to the clinic for reasons other than obtaining contraceptives.

It is notable that 45 percent of all first prescriptions for oral contraceptives among sexually active unwed teenagers are obtained at family planning clinics—44 percent among white teenagers and 58 percent among blacks.

Teens Sexually Active 9 Months or More Before Seeking Help at FP Clinic

Only one in seven teenagers who attend family planning clinics come for contraceptive help before they initiate intercourse. (We pointed out in Figure 8 that the major reason for not using contraceptives given by teenagers who realized they could get pregnant was that they did not expect to have intercourse.) Although about three in 10 come to a clinic soon after initiating sex, most have been sexually active for nine months or more. Indeed, nearly four in 10 teenage patients first come to the clinic because they suspect they are pregnant (three in 10 white patients, four in 10 black patients and nearly seven in 10 Hispanic patients). Fear of pregnancy is the most important reason cited by teenagers for coming to a family planning clinic (cited three times more frequently than the second most important reason—that they just started to have sex).

Figure 40.
Percentage distribution of new teenage patients practicing contraception before and after clinic enrollment, by type of method used, 1976, and distribution of all teenage clinic patients, by type of method, 1978

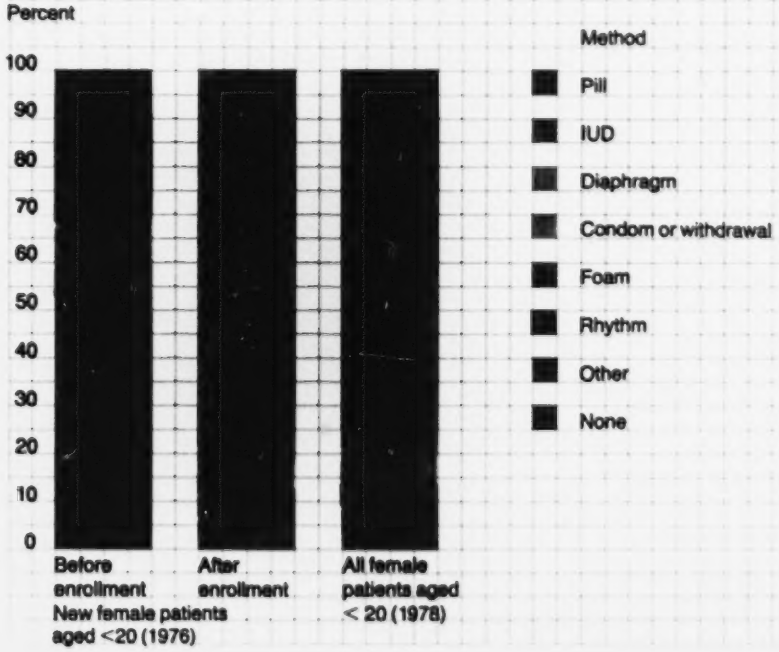
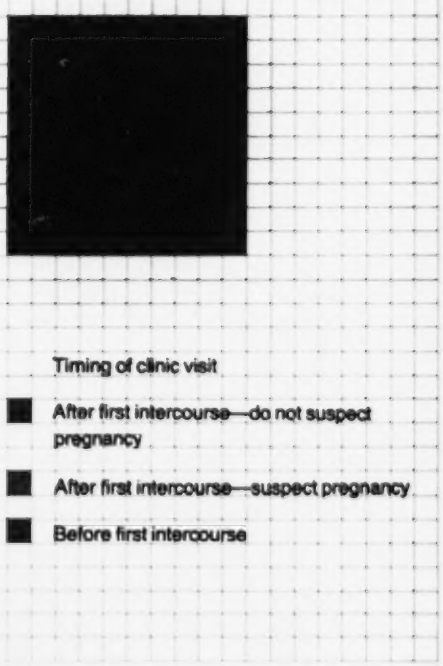


Figure 41.
Percentage distribution of teenagers who came to a family planning clinic, by timing of visit, 1980


Timing of clinic visit
After first intercourse—do not suspect pregnancy
After first intercourse—suspect pregnancy
Before first intercourse

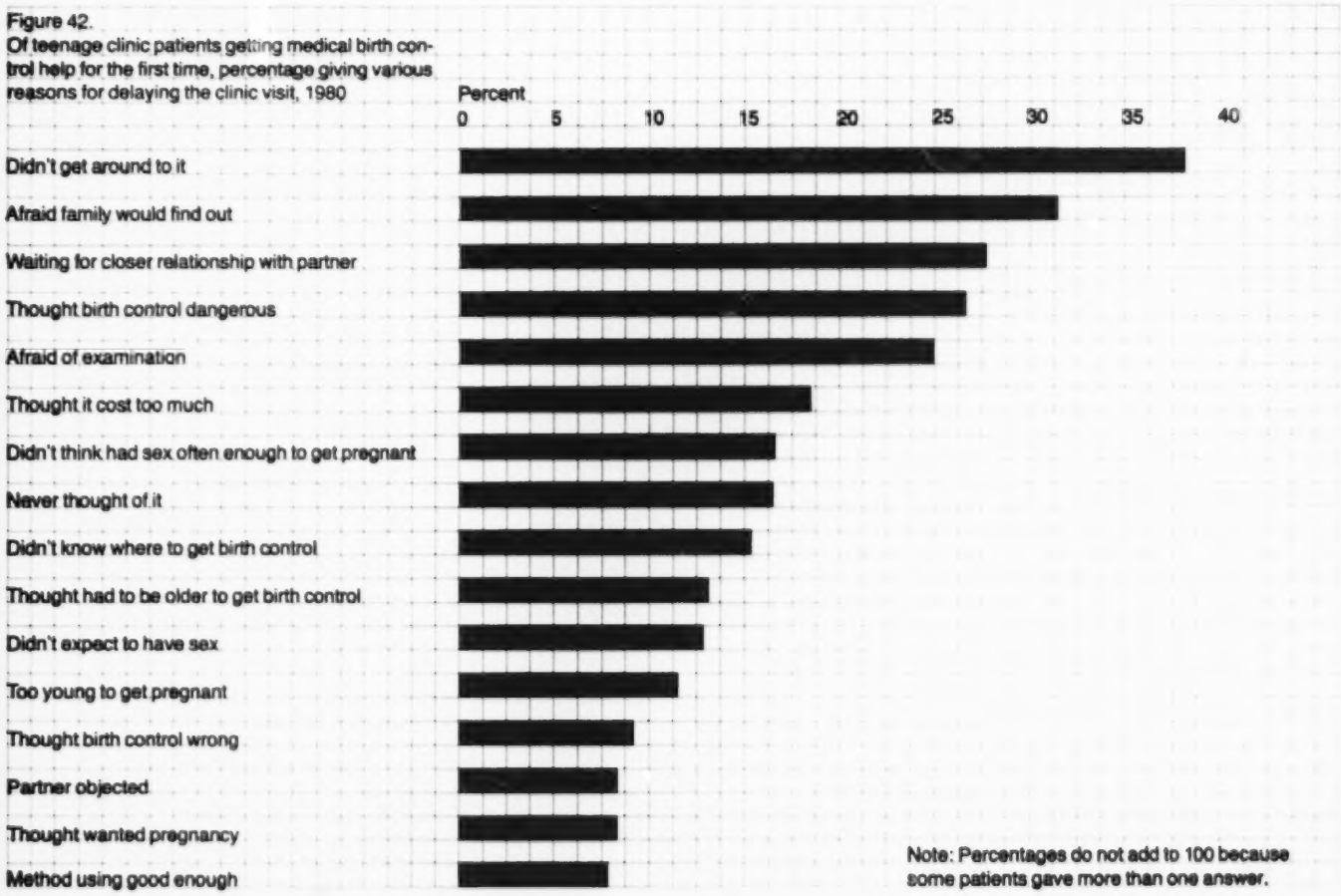
Fear Parents Will Find Out Major Reason Given For Long Delay of Clinic Visit

Delay in obtaining contraceptives is the main reason that such a large proportion of premarital pregnancies among teenagers occur in the first few months after they initiate intercourse. What causes the delay?

Teenage family planning clinic patients getting medical birth control help for the first time cited two major reasons for waiting an average of more than nine months before seeking assistance.

The most frequently cited response was the catchall reason, "I just didn't get around to it." Close behind, and the most important reason specified, was "I was afraid my family would find out if I came." These reasons were closely followed by "waiting until I had a closer relationship with my boyfriend" (and, presumably, could confide about contraception), "thought it was dangerous to use birth control" and "afraid to be examined."

Figure 42.
Of teenage clinic patients getting medical birth control help for the first time, percentage giving various reasons for delaying the clinic visit, 1980



Note: Percentages do not add to 100 because some patients gave more than one answer.

More Than Half of Teen Clinic Patients Have Told Their Parents About The Visit

Well over half of young teenage patients have told their parents about their visit to a family planning clinic; one-fifth of them came to the clinic at their parents' suggestion. The younger the patient, the more likely the parent is to know: Sixty-six percent of patients 15 or younger have informed their parents, as have 52 percent of those aged 16 and 49 percent of 17-year-olds.

However, about one-quarter of young teenage patients would not attend a family planning clinic if their parents had to be informed. The great majority of these would use less efficient nonprescription or folk methods, or would abandon contraception. Only two percent say they would stop having sex.

The U.S. Supreme Court has ruled unconstitutional any law that would require parental consent for provision of nonprescription contraceptives to minors; blanket parental consent laws for medically prescribed contraceptives would also probably be unconstitutional. However, the Court has not yet ruled on state laws requiring parental notification if minors are served, or on parental consent or notification restrictions for minors served under federally funded programs.

If all family planning clinics required consent or notification, some 113,000 minors probably would stop coming to the clinics; some 33,000 would be likely to become pregnant, and have abortions or unintended births.

One-fifth of FP Clinics Require Parent's Consent or Notification for Services

Are family planning clinics likely to tell teenagers' parents that their children are seeking birth control services? About one-fifth of family planning facilities require parental consent or notification as a condition of service for patients aged 15 or younger. However, only about one in 10 clinics have such requirements for patients aged 16-17. Hospitals and freestanding facilities such as community health centers are most likely to have such requirements. While many clinics indicate they waive these rules in exceptional cases (such as those in which they fear that the young person will be abused by her parents), they most typically require the patient to bring her parent or written parental permission in order to obtain birth control services.

Figure 43.
Percentage distribution of family planning clinic patients younger than 18, by whether parents know about their clinic attendance; and, if parents do not know, what patient would do if parental notification were required, 1979–1980

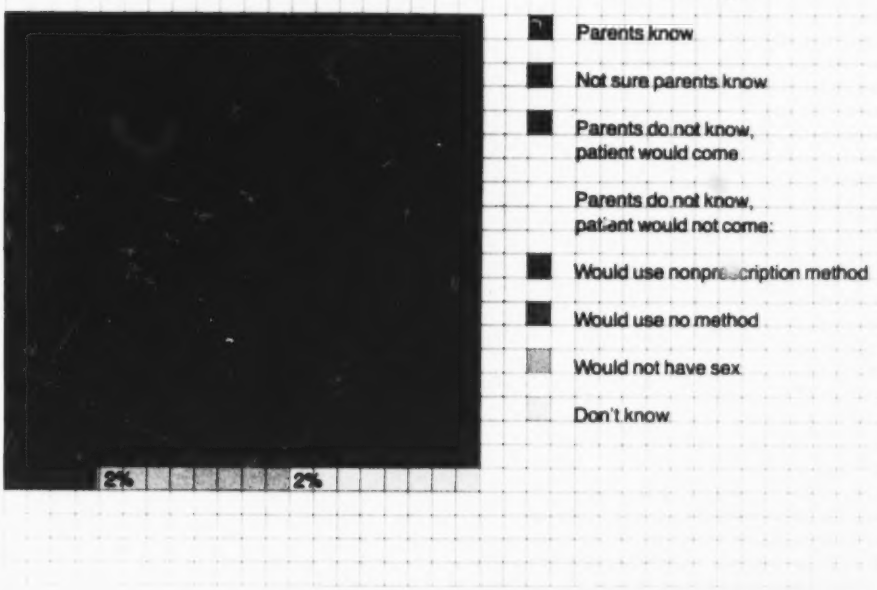
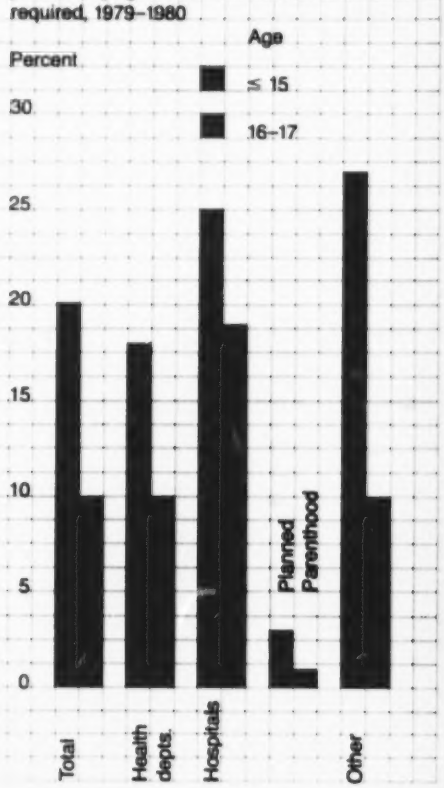


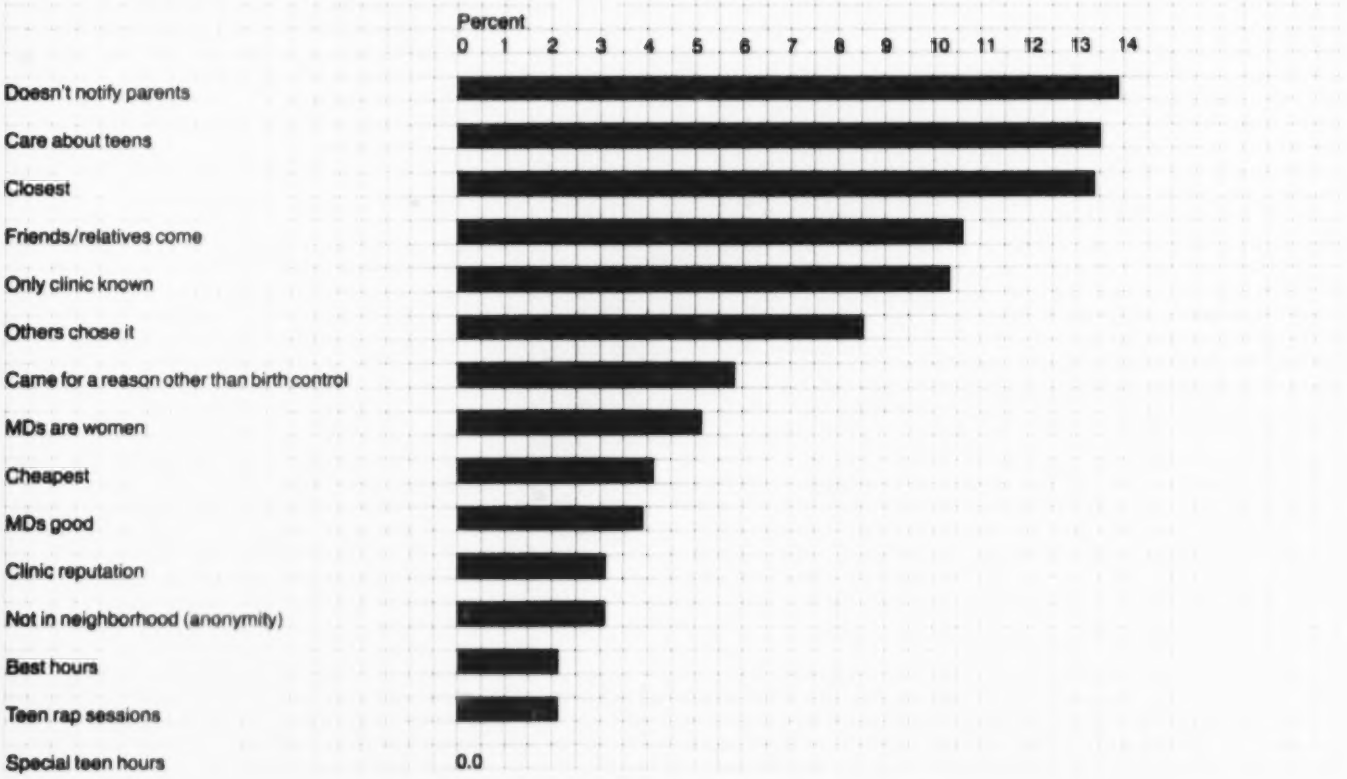
Figure 44.
Percentage of family planning agencies that require parental consent or notification to serve minor patients, by age at which consent or notification is required, 1979–1980



Confidentiality, Caring About Teens Most Important Reasons for Choosing Clinic

When teenage patients were asked the most important reason for choosing the clinic they did, they were most likely to say it was because the clinic did not tell their parents about the visit. This reason was followed closely by the teenagers' belief that the clinic was said to "really care about teenagers," and that it was the closest to where they lived. At the bottom of the list of reasons were the availability of rap sessions, convenient or special teen hours and location outside the teen's neighborhood to preserve anonymity.

Figure 45.
Percentage of teenage patients giving various reasons as most important for choosing a particular family planning clinic, 1980

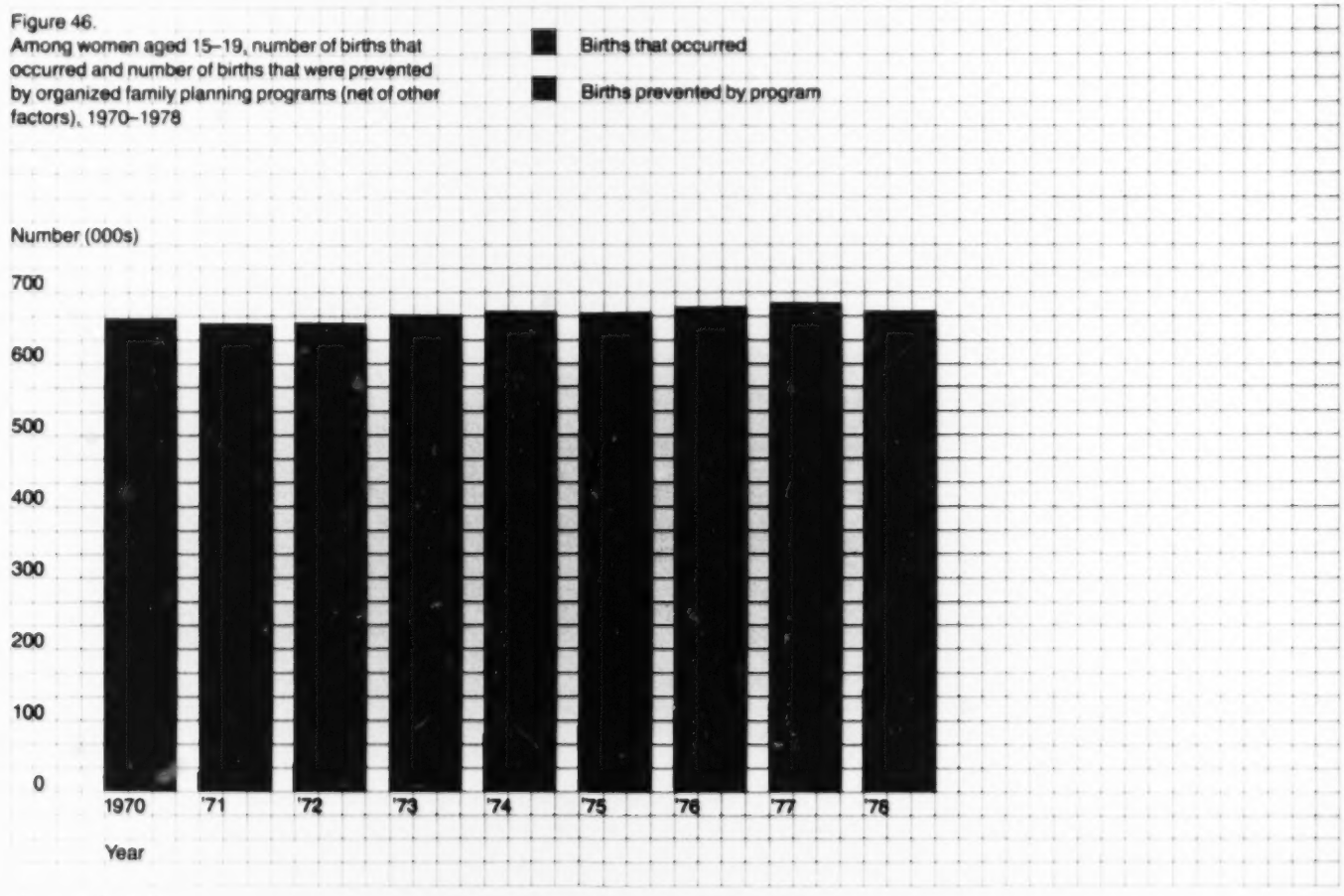


Clinic Services Prevented 689,000 Unplanned Teenage Births in 1970–1978

Had the family planning clinics not existed, there would probably have been 689,000 teenage births in addition to the 4.8 million that actually occurred between 1970 and 1978. A special study analyzed the effect of the family planning program on averting teenage births, independent of other important factors such as socioeconomic status, race, population density, education and levels of female employment. It found that for every 10 adolescent patients enrolled, one teenage birth was prevented, net of other pertinent factors. In 1978, there were 543,000 births to 15–19-year-olds; but there would have been 675,000—24 percent more—if there had been no family planning clinic program.

The number of abortions averted by the program is probably at least as great as the number of births, since adolescent family planning clinic patients are highly motivated to prevent childbearing, and might be expected to be more likely to terminate an unplanned pregnancy by abortion than to have an unwanted birth.

Figure 46.
Among women aged 15–19, number of births that occurred and number of births that were prevented by organized family planning programs (net of other factors), 1970–1978



Four in 10 Sexually Active Teens Not Getting Medical FP Services

There are 4.6 million young women aged 15–19 who are sexually active and who are not intentionally pregnant or seeking pregnancy. These are young women who may be described as "in need" of contraception to prevent unwanted pregnancies. About 1.5 million of them are obtaining services from family planning clinics, and another 1.2 million are estimated to be receiving services from private physicians. About 563,000 are using condoms or spermicides obtained from drugstores, and 617,000 are depending on highly ineffective folk methods—withdrawal, douche or rhythm, without any medical supervision; an estimated 789,000 are having intercourse without using any means to protect themselves against pregnancy.

About five in 10 sexually active 15–17-year-olds are not receiving birth control help from a clinic or a private doctor, compared to four in 10 who are 18 or 19 years old.

Need to Quintuple Research Investment In Order to Develop Major New Methods

Although many teenagers choose the pill—a highly effective method—it is less than ideal for a young person for whom sexual encounters are occasional or episodic. What is more, teenagers are not as enthusiastic about this method as they once were, because of fears that the pill is dangerous. It is also not suitable for young women who have not begun to menstruate regularly. The IUD is often inappropriate for teenagers who have not had children, and, at any rate, increases the risk of pelvic inflammatory disease and, therefore, the likelihood of later fertility impairment.

A new method more appropriate for teenagers, such as a safe postcoital method or a once-a-month method, is desperately needed. While much theoretical progress has been made toward development of these kinds of methods, shrinking research dollars make it unlikely that they will reach the market before the next century.

The U.S. government is currently investing about $12 million a year in contraceptive development, but a least $60 million is needed annually to take advantage of current knowledge to get major new methods such as a monthly pill, a male pill or a vaccination against pregnancy to the market.

Figure 47.
Need for family planning services among women aged 15–19, by age-group, 1978

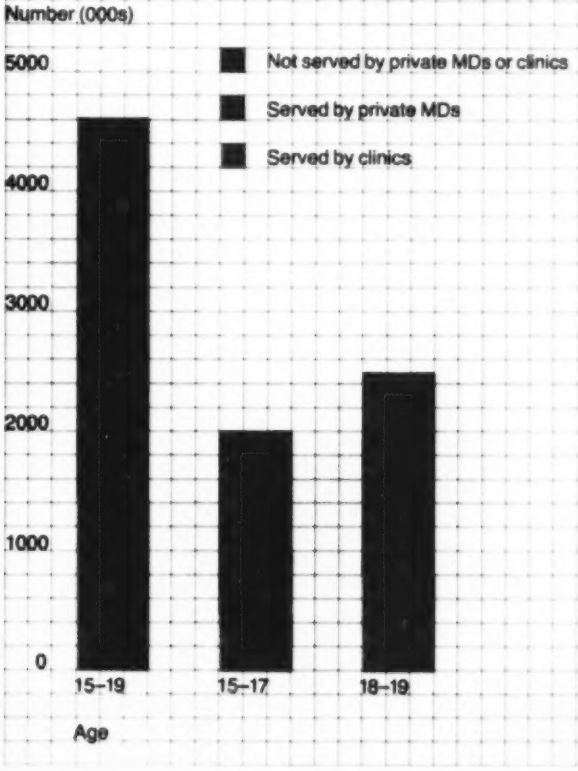
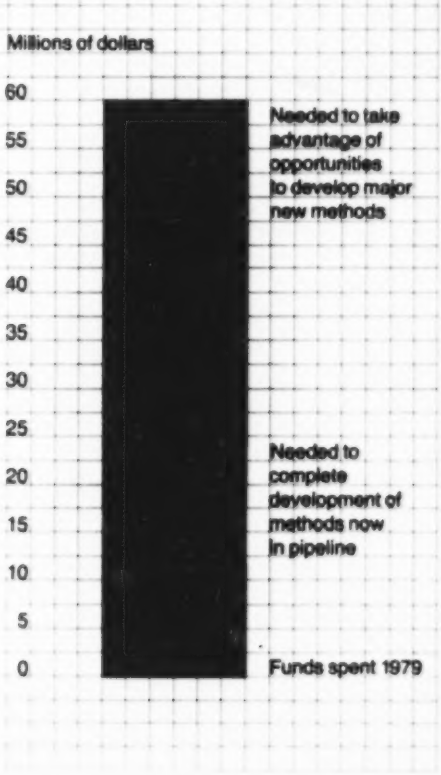


Figure 48.
U.S. government funds spent on contraceptive development, and unmet need, 1979



SECTION 8

Abortion Services

For many teenagers who find themselves confronted with an unplanned pregnancy, abortion is preferable to an unintended birth. The number of abortions obtained by adolescents nearly doubled between 1973 and 1978. Poor and black teenagers were less likely to terminate an unwanted pregnancy by abortion than those who were white and more affluent. However, because unwanted pregnancies were much more prevalent among poor and black teens, their abortion rates were little different from those of the other groups. Increased availability of abortion has not resulted in a relaxation of contraceptive use among teenagers, but has been associated with an improvement in their contraceptive practice.

Because of distance, cost, parental consent requirements, lack of familiarity with the medical system, menstrual irregularities and psychological factors, teenagers are much more likely than older women to delay abortion to the later, more dangerous weeks of pregnancy.

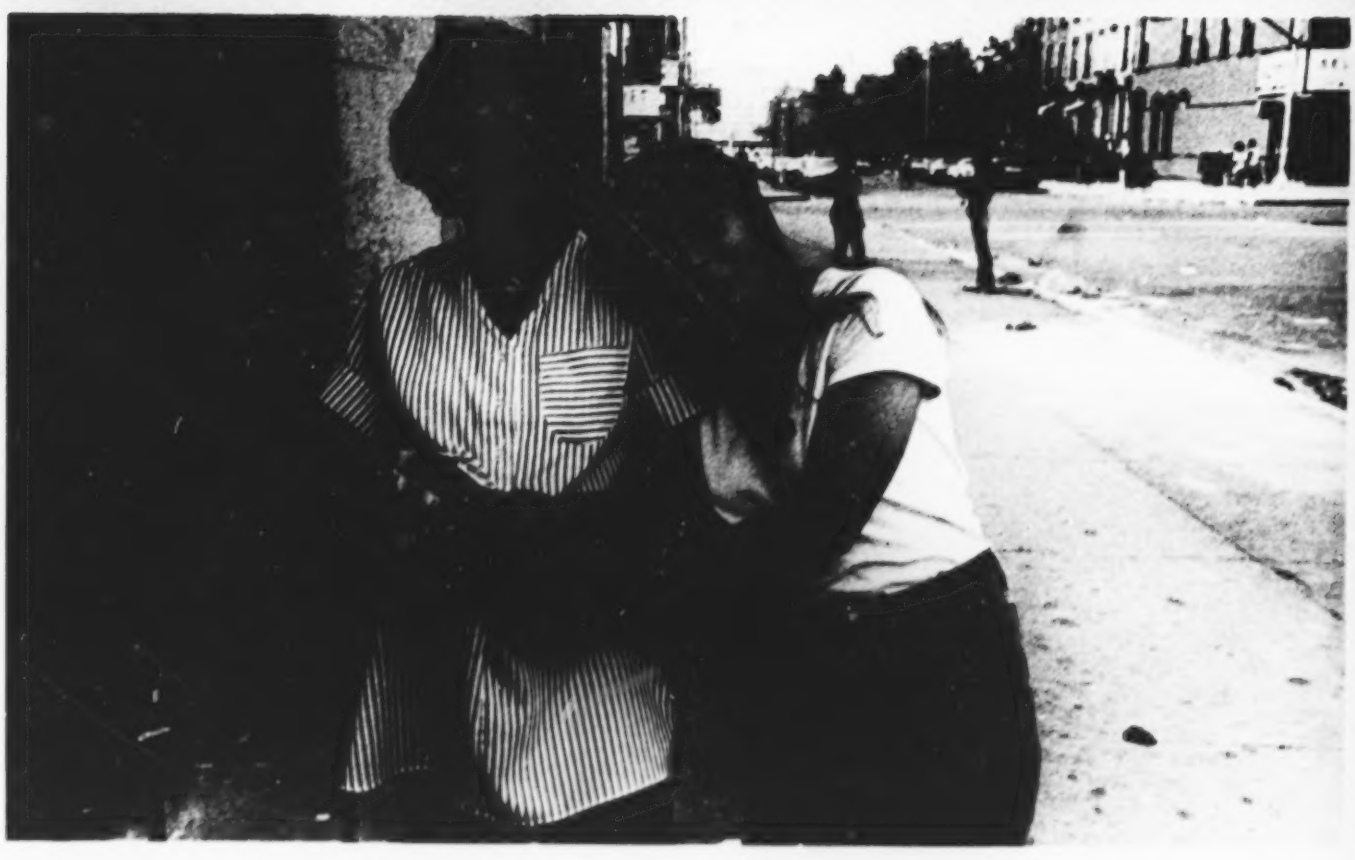
Most U.S. counties have no abortion facilities, and cost has been an increasing obstacle to service since the Supreme Court declared the Hyde Amendment constitutional. (Most young people are dependent on their parents, partners or public funds to pay for
50 their abortions.) Parental consent is required by two-fifths of abortion facilities for at least some teenage patients. Three in 10 teenagers estimated to want and need abortion services in 1978 were unable to obtain them, and their pregnancies resulted in unintended births. As is the case with contraception, most young teenage patients tell their parents about their decision to have an abortion, but a significant minority would not come to the facility if parental notification were required. Thousands of illegal or self-induced abortions and additional unintended births could be expected to result.

SECTION 10

Can the Problem Be Solved?

In 1978, at the conclusion of *11 Million Teenagers*, we wrote that "teenage pregnancy and childbearing is a major unsolved problem in the United States, and ...although we have most of the knowledge and resources needed to solve it, we have failed to do so." We outlined an eight-point national program that included realistic sex education, an expanded network of preventive family planning services, unbiased pregnancy counseling services, equal availability and accessibility of legal abortion services, adequate prenatal, obstetric and pediatric care for teenage mothers and their children, educational, employment and social services for adolescent parents, coverage by national health insurance of all health services related to teenage pregnancy and childbearing, and expansion of biomedical research to develop new safe and effective contraceptives more appropriate to the needs of young people.

We noted that such a comprehensive program—or most of it—could be developed with current knowledge and at a cost that would be reasonable when compared with the huge price already being paid by individuals and society for adolescent pregnancy and childbirth. Since that time, public awareness of the importance of the problem for young
64 people, their families and the society has be-



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434,000 Abortions Among Teens in 1978, Nearly Twice the Number Obtained in 1973

In 1973, 246,000 abortions were obtained by women 19 and younger; by 1978, that number had nearly doubled to 434,000; the proportion of teenagers obtaining abortions rose from two to four percent.

Throughout the decade, about three in every 10 abortions were obtained by teenagers—2.2 million abortions between 1972 and 1978.

Women aged 15–19 terminate nearly two-fifths of their pregnancies by abortion, compared to more than half of all pregnancies among girls younger than 15.

About nine in 10 teenagers who obtain abortions get them in freestanding clinics. Teenagers are much less likely than older women to go to a hospital for an abortion.

Poor Pregnant Teens 2/5 as Likely To Obtain Abortions as More Affluent

In general, the higher a teenager's socioeconomic status, the more likely she is to terminate a pregnancy by abortion, regardless of race. In Rhode Island, a state whose population is disproportionately white and Catholic, 56 percent of all pregnancies to teenagers living in the highest socioeconomic-status areas were terminated by abortion in 1978, and 32 percent resulted in live births. Among teenagers living in poverty areas, 22 percent of pregnancies resulted in abortions, and 63 percent, in live births.

As with race, poverty status is associated with a disproportionately high number of unwanted pregnancies. Therefore, although pregnancy rates are relatively high among poor women, the percentage of poor and pregnant women who obtain abortions is about the same as the percentage of more affluent women who do so.

Figure 49.
Number of abortions obtained by women younger than 20 and 20–44, 1973–1978

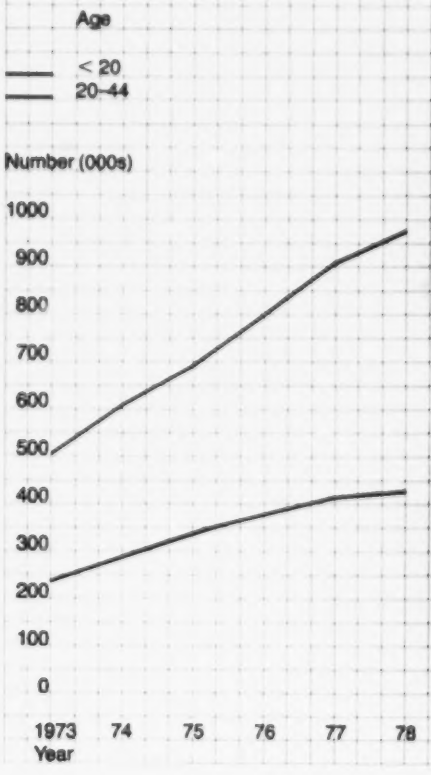
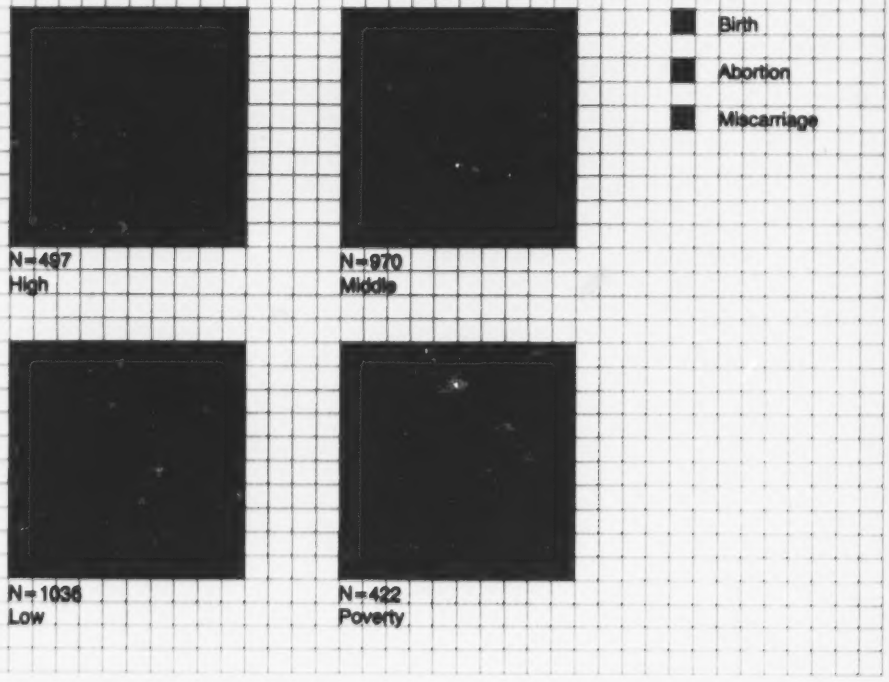


Figure 50.
Percentage distribution of teenage pregnancies, by outcome, according to woman's socioeconomic status, Rhode Island, 1978



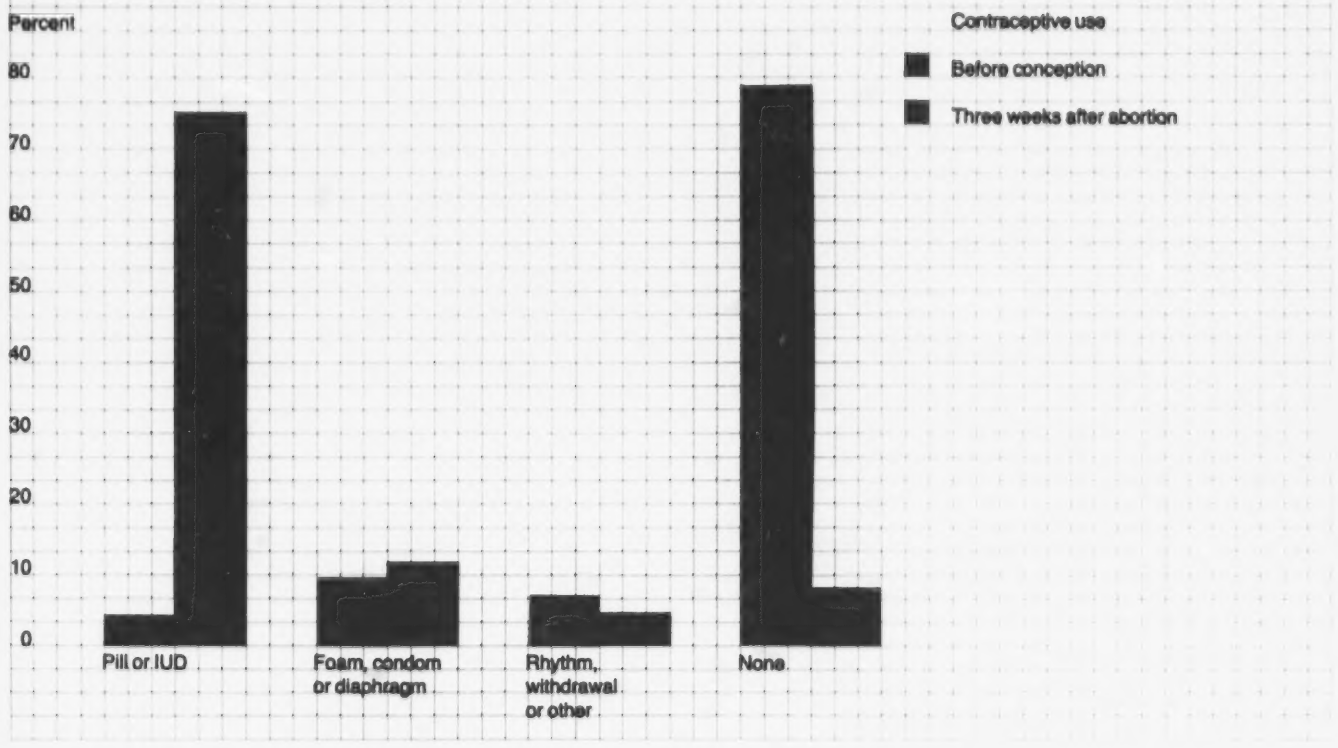
Abortion Availability Leads to Better, Not Poorer, Contraceptive Use by Teens

The availability of legal abortion has not resulted in a relaxation of contraceptive vigilance among teenagers. As we noted earlier, the pregnancy rate among sexually active adolescents has declined by 22 percent since abortion was legalized (see Figure 12) and contraceptive use has increased by 35 percent (see Figure 4).

Indeed, there is strong evidence that teenagers practice contraception much more effectively after they have had abortions than they had before. One study involving nine clinics in eight states showed that eight in ten teenagers coming to a clinic to obtain abortions had used no method of contraception prior to the procedure, and only four percent had used the IUD or the pill. Three weeks following the abortion, only nine percent were not using any method and 83 percent were using the pill or IUD.

The Johns Hopkins National Survey of Young Women found that teenagers whose first pregnancy ended in abortion were only half as likely to become pregnant a second time within the following year than those whose first pregnancy resulted in a live birth (see Figure 15).

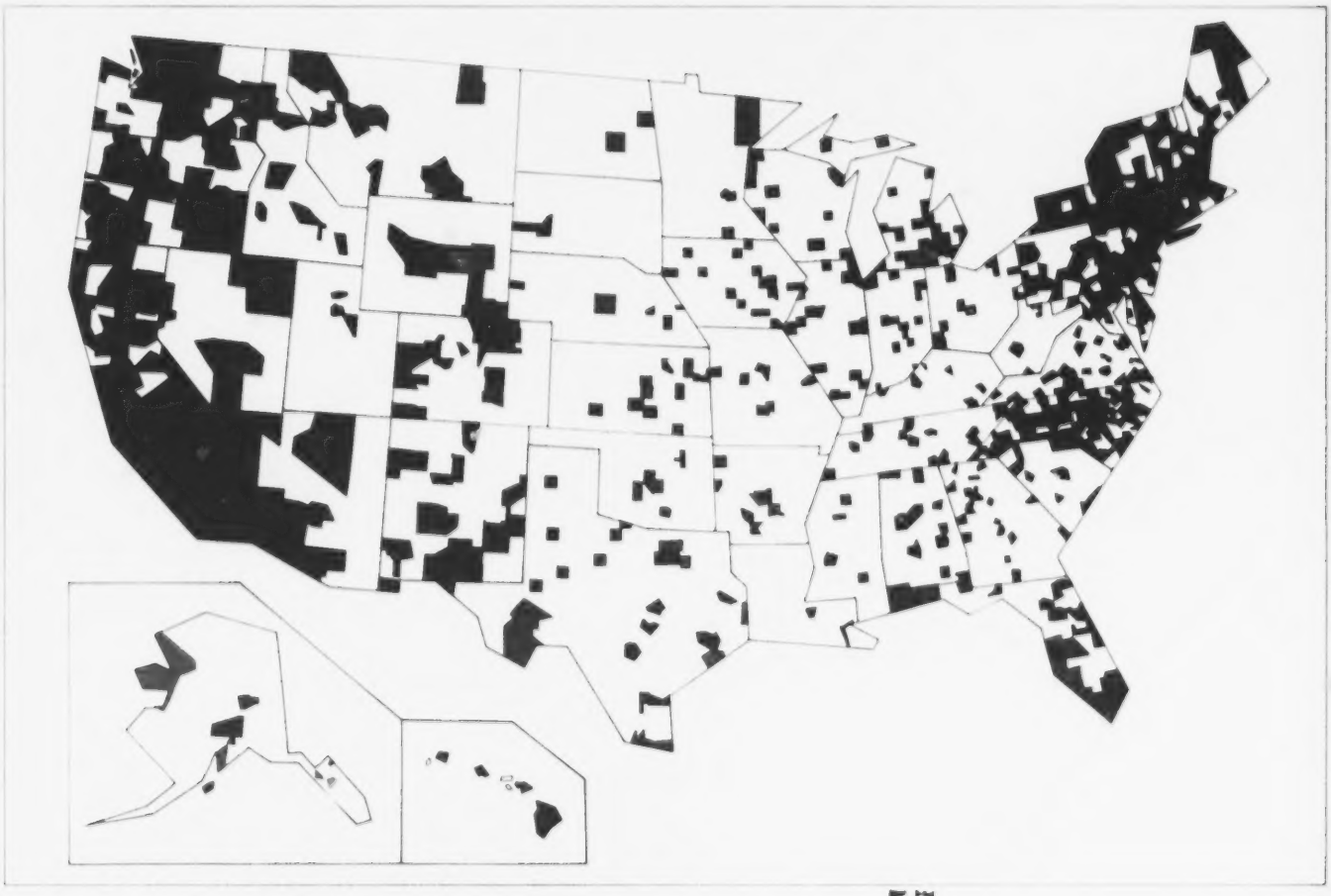
Figure 51.
Percentage distribution of women younger than 20 who obtained abortions, by methods of contraception used before conception and three weeks after the abortion, eight states, 1980 (N=445)



1/4 Million Teens in Need of Abortions Live in Areas Without Enough Facilities

Only 23 percent of U.S. counties have any facility providing abortions, and only 16 percent of counties have a facility providing as many as 30 abortions a year. Some 225,000 teenagers estimated to be in need of abortion services live in such unserved or poorly served counties. The need to travel to other, sometimes distant, communities to obtain abortions places a special burden on teenagers, who are often unable to afford the increased cost involved in travel and overnight stays, and are generally not familiar enough with the medical system to find out-of-town facilities that will serve their needs. Services are especially sparse in nonmetropolitan areas of the country. In Mississippi, the Dakotas and West Virginia, three-quarters of those in need of abortions live in counties that have no abortion facility.

Figure 52.
U.S. counties with at least one identified abortion provider, by number of abortions reported, 1978



*All abortions > 5 rounded to nearest 10.

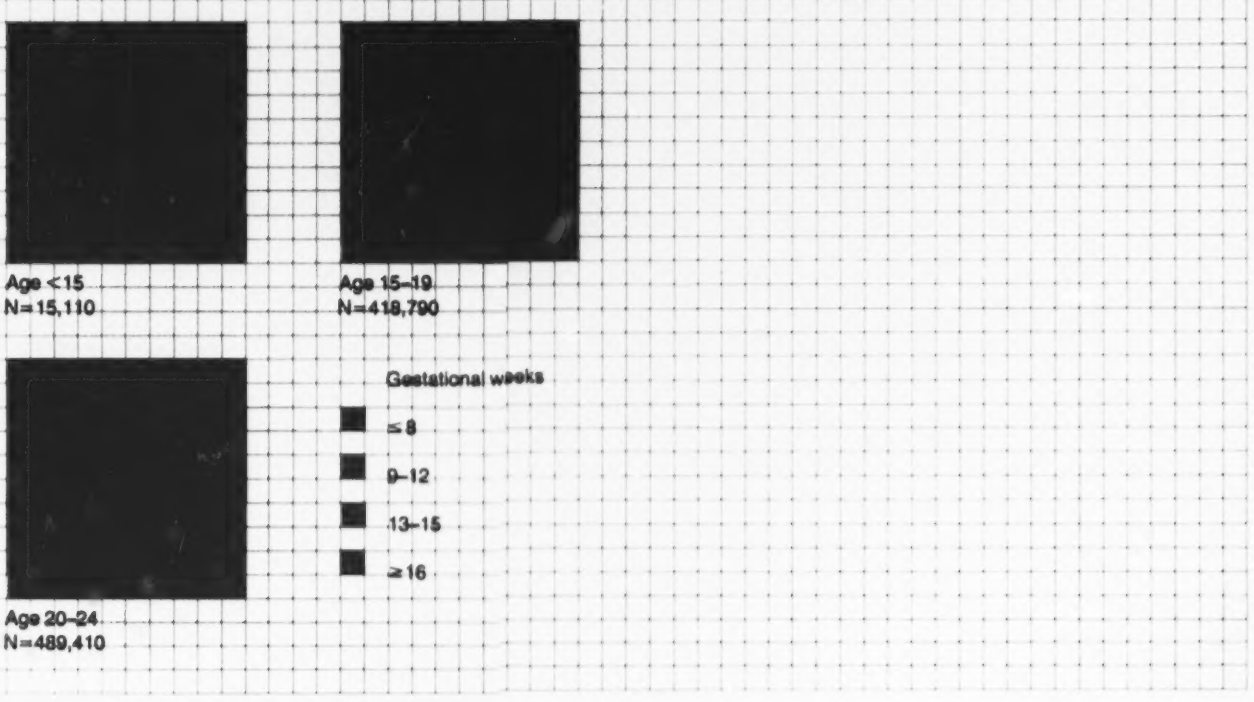
Teens More Likely to Delay Abortions To Later, Riskier Weeks of Gestation

Teenagers are less likely than women in their 20s to obtain abortions at the safer, earlier weeks of gestation. The younger the teenager, the more likely she is to have a delayed abortion. Thus, only 34 percent of abortions obtained by girls aged 15 and younger are performed at eight or fewer weeks' gestation, compared to 41 percent of abortions among 15–19-year-olds and 51 percent of those obtained by women aged 20–24. At the other extreme, 14 percent of abortions obtained by girls younger than 15 are performed at 16 weeks' gestation or later, compared to just seven percent of abortions among those aged 15–19 and four percent of abortions among women aged 20–24.

The risk of death and major complications from abortion rises with every week the procedure is delayed after the eighth week. Abortions that are delayed to the 16th week or later are as much as 13 times more dangerous than those performed at eight or fewer weeks.

Many factors have been cited as responsible for this delay, including difficulty of access because of geography (eight in 10 counties have no facility providing abortions). Fifty-five percent of teenagers who obtain abortions have to travel to other, often distant, counties to get them; such travel is usually more of a problem for teenagers than adults. Cost, an especially acute problem since the Hyde Amendment and its state counterparts cut off most public funding for abortions, also hinders access. Parental consent requirements, lack of familiarity with the medical system, irregular menstrual patterns and the psychological tendency of some young people to deny unpleasant truths are other factors that are believed to lead to delay.

Figure 53.
Percentage distribution of legal abortions to patients 24 and younger, by age of patient and number of gestational weeks, 1978



4 in 10 Abortion Facilities Ask Parental Consent; Most Teens Already Told Parents

The Supreme Court has ruled unconstituional any law requiring abortion facilities to ask for parental consent before providing abortion services to minors. However, more than four in 10 facilities do impose such requirements for girls aged 15 and younger; three in 10 require parental consent or notification even for 17-year-olds.

More than half of the minor patients now attending abortion clinics have already told their parents about their visit; the younger the teenager, the more likely her parents are to know—or even to have suggested that their daughter obtain an abortion. However, about one-quarter of teenagers have not, and would not, tell their parents. If required parental involvement were extended to all abortion facilities, we could expect some 19,000 young teenagers who now obtain legal abortions to resort to dangerous self-induced or illegal procedures, and about 18,000 more to have unwanted births.

Few Young Teens Can Afford Abortions; Most Depend on Parents, Partner, Medicaid

More than nine in 10 young women aged 17 or younger rely on their parents, partners or Medicaid to pay for their abortions. Two-fifths of abortions obtained by girls 15 and younger are paid for entirely by the parents, one-fifth, by the partners and one-fourth, by Medicaid; in one-tenth of the cases, the cost is shared by the patient and her parents or partner. Only one in 25 abortions obtained by girls in this age-group are paid for by the young patient alone. As the teenager grows older, the abortion is more likely to be paid for by the partner than the parent, but even among 17-year-olds, only about one out of 10 patients pays for the abortion herself.

These data are for the end of 1979 and the beginning of 1980, when many states were paying for Medicaid abortions under court order. Since the 1980 Supreme Court decision upholding the constitutionality of the Hyde Amendment, it is doubtful that as many as one-fifth of teenage abortions are still being covered by Medicaid.

Figure 54.
Percentage of abortion facilities that require parental consent or notification to serve minor patients, by type of facility, according to age at which consent or notification is required, 1979–1980

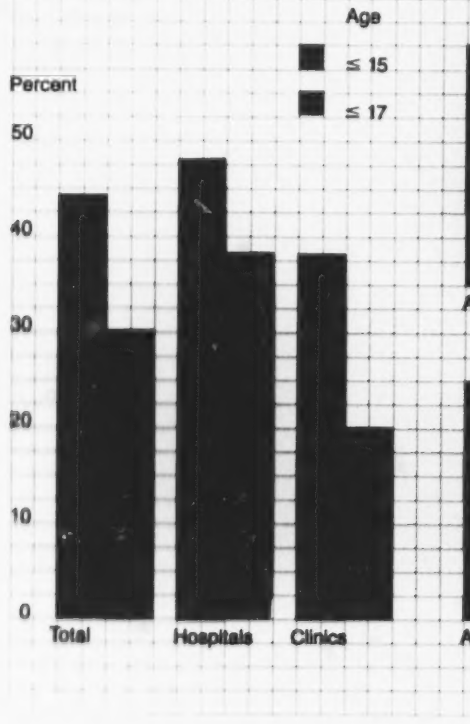
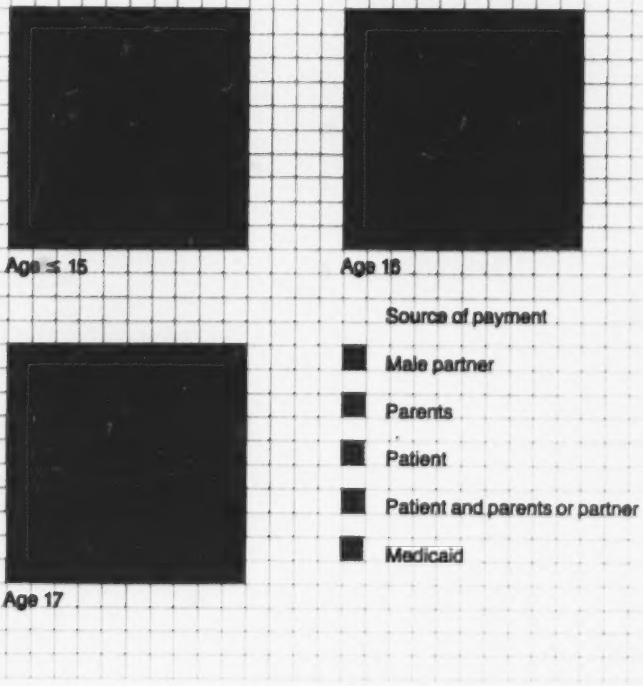


Figure 55.
Percentage distribution of women younger than 18 obtaining abortions, by source of payment, according to age, 1979–1980

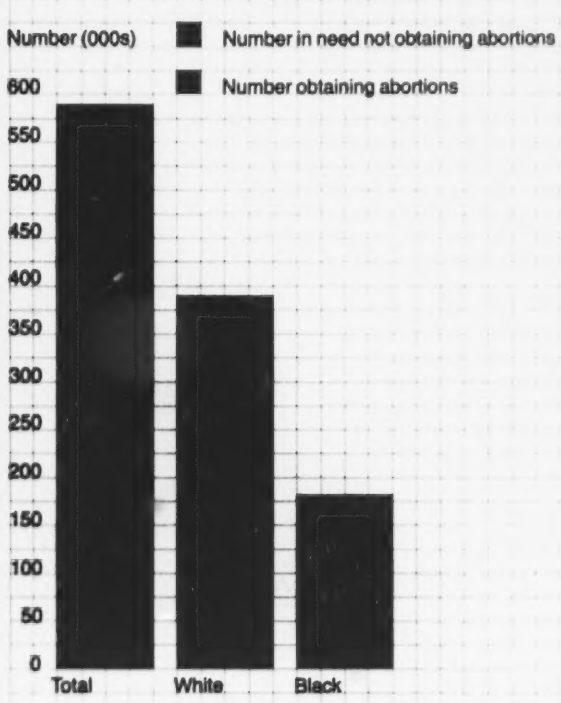


160,000 Teenagers Who Wanted Abortions In 1978 Were Unable to Obtain Them

It is estimated that if abortion services had been fully available and accessible in 1978, at least 579,000 women aged 15–19 would have obtained the procedure. About three in 10 of the teenagers estimated to want and need abortion services were unable to obtain abortions—a total of 160,000 teenagers who, as a result, had unintended births. These represent about six in 10 of all teenagers who had unintended births.

At least two in 10 white and four in 10 black teenagers in need of abortion services in 1978 were unable to obtain them.

Figure 56.
Number of women in need of abortion services, and number obtaining abortion services, by race, 1978



but, as the Surgeon General has pointed out, "a substantial proportion of school districts still encourage teenage mothers to drop out of school." Even if school continuation is encouraged, teenage parents—especially adolescent mothers—face enormous and sometimes insuperable difficulties in arranging for child care.

Unwed adolescent mothers who live with their parents apparently are better able than those who live alone to complete their educations and become self-supporting. In many communities, however, welfare policies preclude giving financial assistance to adolescent mothers who continue to live in their parents' homes. Such policies should be revised so as to encourage rather than discourage parental help to teenage mothers.

While there has been a sharper increase in out-of-wedlock childbearing among white, more affluent teenagers, the problem is still much more acute among poor and minority youth. If educational, vocational and welfare assistance is not forthcoming, many of the children of these teenage parents will grow up in poverty and become adolescent parents themselves. Providing effective health and social services for adolescent parents and their children is costly. Just to establish networks of existing programs for the 186,000 teenagers 17 and younger who became mothers in 1978 could cost about $150 million a year.

Increasing the availability of sex education, family planning, abortion services and health care to teenage mothers and their babies will not resolve the growing problem of adolescent pregnancy. The Select Panel for the Promotion of Child Health has correctly pointed out that a job-training program in a high-risk area may do as much or more to reduce adolescent pregnancy than an adolescent health clinic. However, even programs such as job training are not enough in themselves. Teenagers, especially those who are very poor, need to believe that completing their educations can really lead to meaningful options in the world of work—that there is potentially more out there for them than dead-end, low-paying jobs.

Need Comprehensive Effort

No one program can possibly solve the many problems that are associated with teenage pregnancy or deal with the basic causes of adolescent alienation. Yet we believe that the outlines of a national program to stem the crisis are fairly clear and that much of the knowledge about what needs to be done is available.

The reason that more progress has not been made is not simply the result of a lack of will. Nobody wants to see a continued increase in adolescent pregnancies and childbearing. But the solution—or solutions—must come from many elements of the society: federal, state and local legislatures and government agencies, the schools, the churches, parents, the media, youth organizations, health and social agencies. Various elements of a comprehensive program and different approaches to it have been advocated and promoted. But there is not yet a consensus about all of the means or a willingness to pay the necessary costs. Too often, support for maternal and child health is traded off against preventive efforts such as family planning and abortion; or research into a new contraceptive method is given low priority because of the long lead time needed for its development. While the fact of teenage sexuality is painfully obvious, many parents still hope that if information is withheld from *their* children, they will delay sex until marriage. All too often the result is opposition to meaningful sex education programs that give information to young people *before* they start to have sex and risk pregnancy. Most people agree about the importance of prenatal, postnatal and well-baby care for teenage mothers and their children, but there is not yet the willingness to pay the costs for such progams in most communities of the nation.

Teenage pregnancy—the problem nobody wants—has not gone away. Nor will it, unless there is heightened awareness and commitment, and a willingness to abandon simplistic approaches, to take bold and often controversial steps and to pay the necessary price.

We hope that in these pages we have provided some of the information needed to understand the nature of the problem, what is being done to solve it, the enormous needs that are still unmet and the kinds of efforts that must be made to meet them.

SECTION 9

Services to Pregnant Teenagers, Adolescent Parents and Their Babies

Excellent and timely prenatal care can help avert many of the damaging health consequences of early childbearing to mother and baby, but teenage mothers are far more likely than those who give birth in their 20s to have no care or to get it too late. The younger the teenager, the worse the situation. Part of the reason for the delay is that teenagers are far less likely to be able to pay for care themselves or to be covered by health insurance; they are much more dependent than older mothers on Medicaid and other government funding sources.

Although there are a growing number of special programs for pregnant teenagers and teenage mothers, such programs continue to be small, scattered and largely educational.

Most cities with special programs report that infant day-care services are inadequate and that more social services for teen mothers are needed. Few teenage parents have finished high school; many are unable to get education and job training because of problems associated with child care.

Sources and Detailed Notes

Figure 1. Male population aged 13–21 and female population aged 13–19: U.S. Bureau of the Census, "Population Estimates and Projections," *Current Population Reports* (*CPR*), Series P-25, No. 870, U.S. Government Printing Office, Washington, D.C. (GPO), 1980, Table 1. **Male and female marital status:** U.S. Bureau of the Census, "Marital Status and Living Arrangements," *CPR*, Series P-20, No. 338, GPO, 1979, Table 1. **Proportion of females aged 15–19 sexually active:** Extrapolated for 1978 from 1979 estimates for metropolitan areas in M. Zelnik and J. F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971–1979," *Family Planning Perspectives*, 12:230, 1980, Table 1; and from unpublished tabulations for metropolitan areas and all areas from the Johns Hopkins Survey of Young Women, 1976, M. Zelnik and J. F. Kantner. **Proportion of females aged 13–14 sexually active:** Estimate based on 1976 and 1979 distributions, by single years of age, from M. Zelnik and J. F. Kantner, 1980, op. cit., and M. Zelnik and J. F. Kantner, "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," *Family Planning Perspectives*, 9:55, 1977. **Proportion of males aged 17–21 sexually active:** M. Zelnik and J. F. Kantner, 1980, op. cit., Table 2. (Proportions used are for metropolitan areas only.) **Proportion of males aged 13–16 sexually active:** Estimate assuming proportion of males was 10 percent higher than that of females at each age.

72 **Figure 2. Proportion of metropolitan-area wom-**

Most of Young Teens Get No Prenatal Care In 1st Trimester; 1/5 Get None Before 3rd

Many of the damaging health consequences of early childbirth to the mother and the baby can be averted by early, high-quality prenatal care. Prenatal care has improved for mothers in all age-groups in recent years, but teenagers—those at highest health risk from pregnancy and childbirth—continue to get the least adequate medical attention.

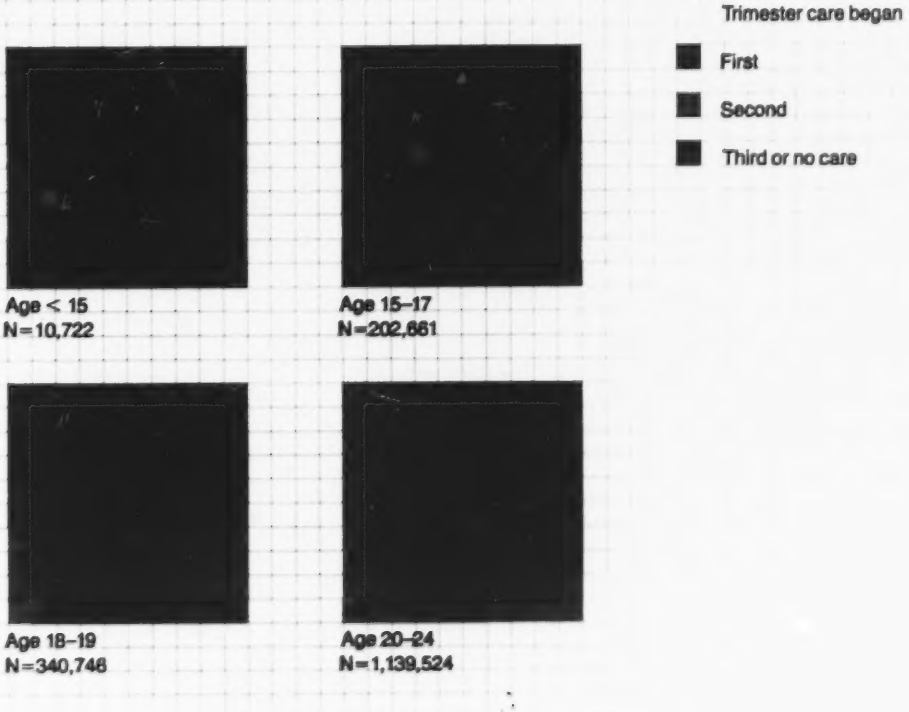
In 1978, two-thirds of the 11,000 mothers under age 15 received no prenatal care during the critical first three months of pregnancy, and one-fifth got no prenatal care or got none until the last trimester of pregnancy.

Half of the 203,000 mothers aged 15–17 got no care in the first trimester, and one-eighth received no care or none until the last three months. For those aged 18–19, the comparable proportions were two-fifths and one-tenth.

Among the 1.1 million mothers aged 20–24, one-fourth had no prenatal care in the first trimester; care was delayed until the last trimester or absent altogether for only one in 18.

In other words, mothers under age 15 are two and one-half times more likely than mothers aged 20–24 to be without prenatal care in the first trimester, and nearly four times more likely not to get care at all or to delay it until the last trimester. Mothers aged 15–17 are two times more likely than those aged 20–24 to receive no care in the first three months of pregnancy and to have no prenatal care or none until the last trimester.

Figure 57.
Percentage distribution of mothers younger than 25 obtaining prenatal care, by trimester during which care began, according to age-group, 1978



3–5 Times More Teens Than Older Women Depend on Government to Pay for Delivery

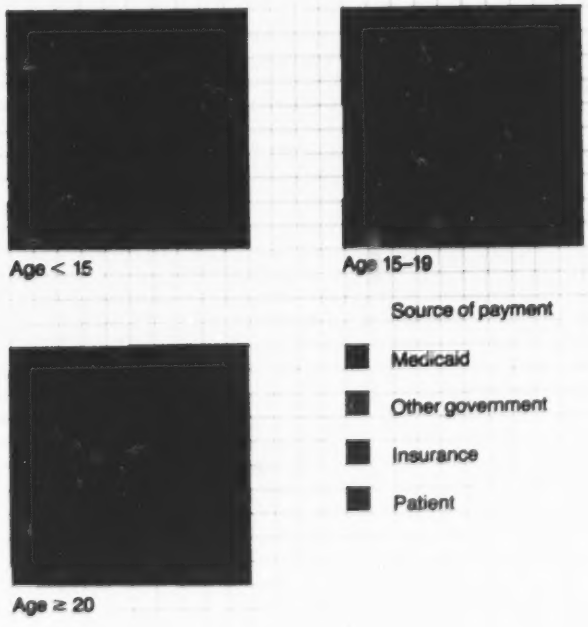
Teenagers are far more dependent upon the government to pay for their deliveries than are mothers over age 20, who are most likely to pay through private insurance.

Data from Rhode Island indicate that 69 percent of births to girls under age 15, and 46 percent of those to 15–19-year-olds, are paid for from public funds, compared to just 14 percent of births to women 20 and older. Medicaid is the source of funding for 19 percent of deliveries to teenagers, but just five percent of births to women 20 and older.

Private insurance, on the other hand, pays for 79 percent of births to women 20 and older, but for only 39 percent of births to 15–19-year-olds and for 19 percent of deliveries to mothers under age 15. (About 1.6 million U.S. teenagers have no health insurance.)

Teenagers are also about two times more likely to have to pay for the delivery out of their own pocket (or out of their parents' or partner's) than women 20 and older.

Figure 58.
Percentage distribution of deliveries, by source of payment for delivery, according to age of mother, Rhode Island, 1978



Most Programs for Pregnant Teens Small; Fewer Than 20% of Pregnant Teens Served

Of 125 cities with populations of 100,000 or more surveyed, 107 reported that they had some kind of special program for pregnant teenagers. Most of the programs were small; only 31 of the cities had programs that provided services for 1,000 or more teenagers a year.

Of the responding cities, about eight in 10 had programs that provided counseling and classes in nutrition, family life and health; three-quarters offered sex education. Only half referred for or offered contraceptive services; only two-fifths had pregnancy testing; and one-quarter offered abortion services.

In 92 of those cities that provided data, only 20 percent of the teenage mothers who had given birth during the year were served by the special programs. Since respondents were the largest cities with the most advanced programs, it is almost certain that substantially fewer than 20 percent of pregnant teenagers were served by such programs nationwide.

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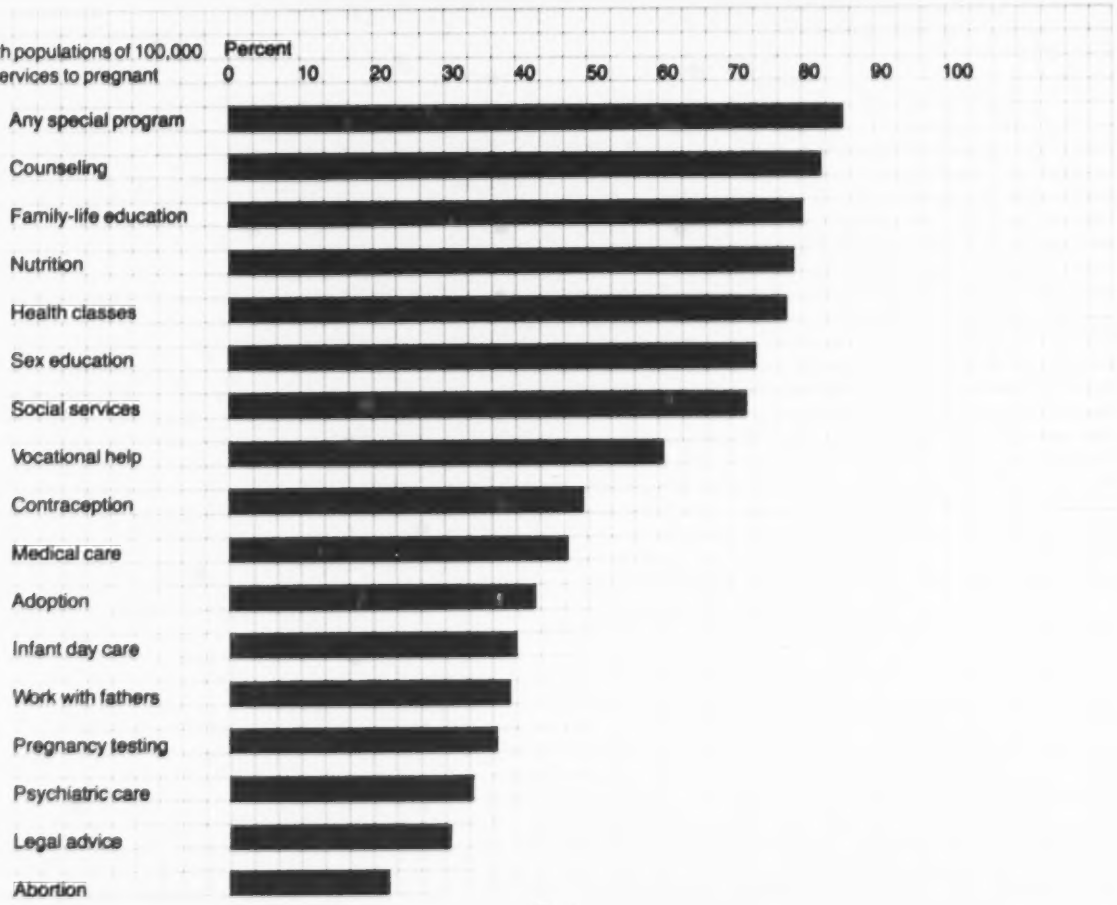
Figure 59.
Percentage of 125 cities with populations of 100,000 or more that offer various services to pregnant teenagers, 1978

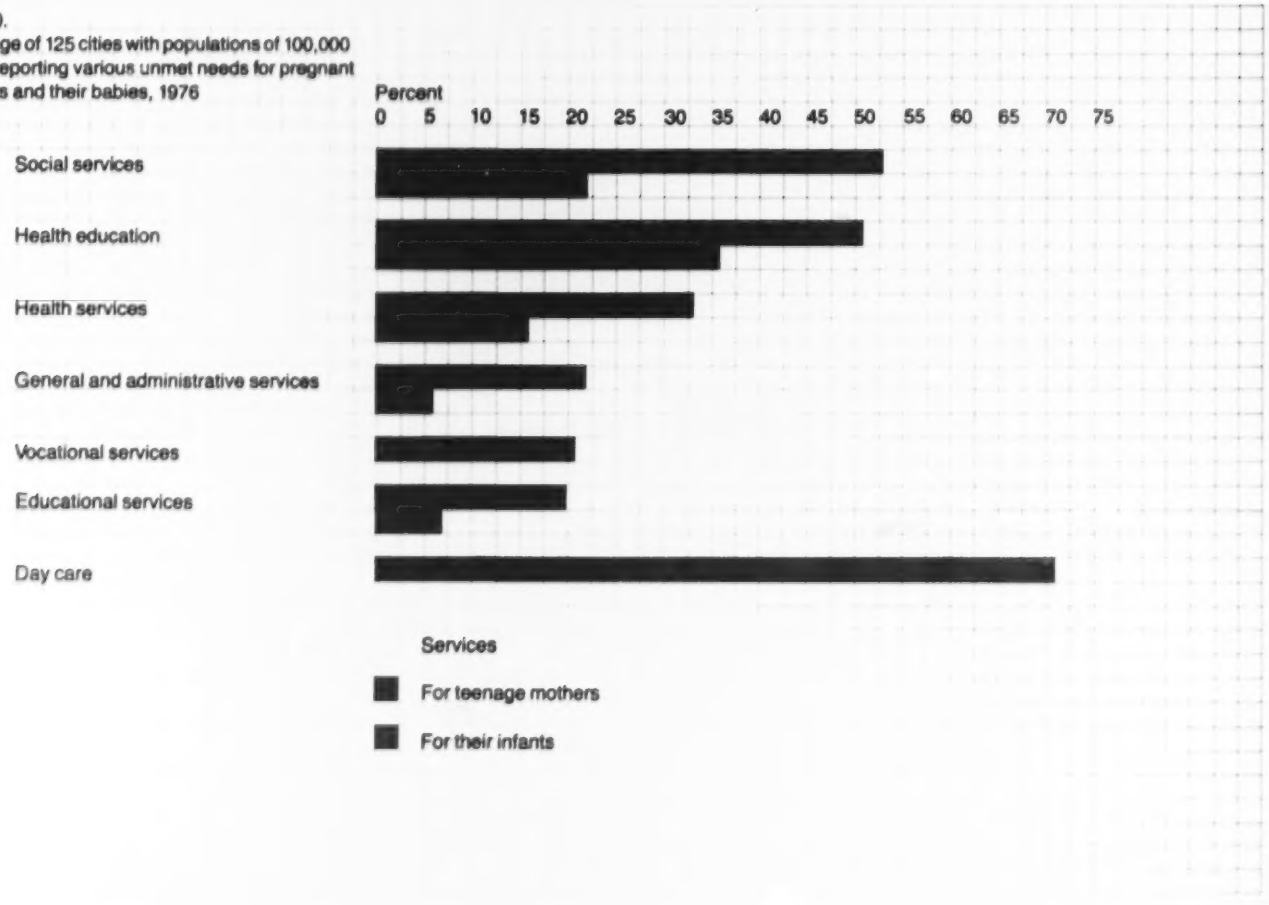


Unmet Needs: Day Care for Teens' Babies, Social Services for Young Mothers

According to the findings of the nationwide study of 125 large cities, the most significant unmet needs for teenage mothers and their babies are facilities, funds and staff to provide infant day care. Seven out of 10 cities responding said that day-care services for the babies of teenage mothers were inadequate.

For the teenage mothers, the major needs reported were for such social services as outreach, support, foster care, legal assistance, psychological counseling and prevention of child abuse. Family life, parenting, contraceptive and sex counseling were rated as the second most important unmet needs for teenage mothers. The need for preventive health services such as contraception, abortion and pregnancy testing was cited less often, either because these services were more readily available in the responding cities or because the professionals responding did not consider them of great importance.

Figure 60.
Percentage of 125 cities with populations of 100,000 or more reporting various unmet needs for pregnant teenagers and their babies, 1976



2/3 of 1.1 Million Teenage Mothers Have Not Finished High School

Of the 1.1 million teenage mothers, about 670,000 have not finished high school. Among the 18-year-old mothers, presumably of graduation age, nearly six in 10 have not completed high school; of those who are 19, a year beyond average high school completion age, more than four in 10 have not received a diploma. Although most teenage mothers want to complete their high school education, and even get further academic or vocational training, they are hampered by economic and child-care problems.

804,000 Children of Teen Mothers In Need of Day-Care Services

Of the 1.3 million children with teenage mothers, only about 43,000 are enrolled in day-care programs, and an estimated 480,000 are taken care of by nonworking mothers, relatives or baby-sitters. Most of the remaining 804,000 children are in need of day-care services because their mothers would like to work or finish high school. As a result of the unavailability of child-care services, many mothers are unable to complete their educations or hold a job and are dependent on welfare.

Figure 61.
Number of mothers younger than 20 who have and have not completed high school, by age of mother, 1978

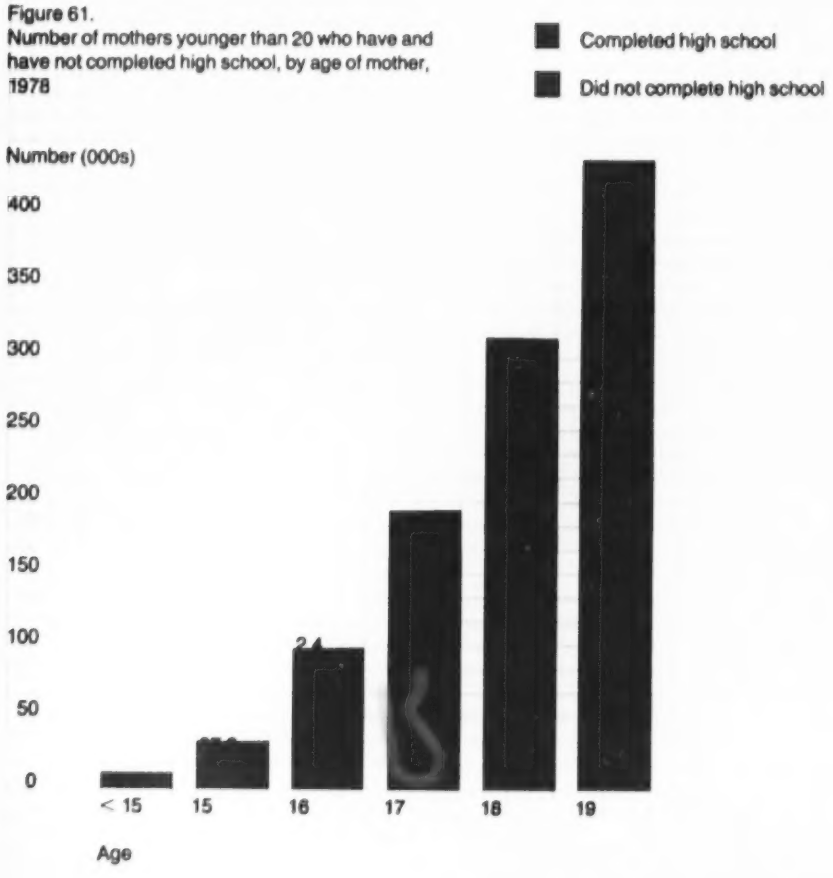
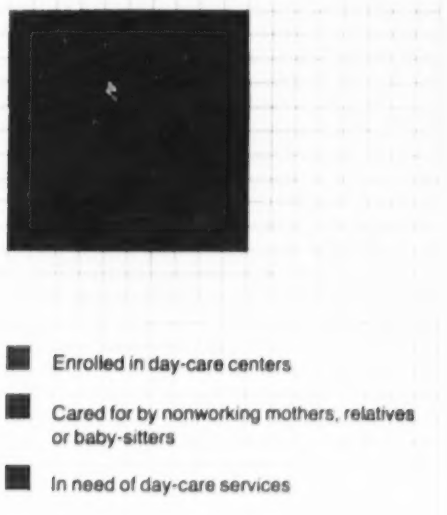


Figure 62.
Distribution of 1,327,000 children of teenage mothers, by need for day-care services, 1978 (numbers in 000s)



come virtually universal. What is more, the elements of a comprehensive national program have been put forward, with varying emphases, by a number of broad-based official and semiofficial groups.*

Despite the growing public concern and the plethora of reports, there has been little action to solve the problem. A highly publicized initiative of the Carter administration did lead to the passage in 1978 of the first legislation aimed specifically at reducing the consequences of teenage pregnancy. However, the Adolescent Health, Services, Pregnancy Prevention and Care Act, despite its ambitious title, addressed only one aspect of the problem—the need for a variety of supportive services to pregnant girls, teenage parents and their infants. Furthermore, the program was designed in large part to help link existing medical, social, vocational and child-care services for teenage parents and their children, although many experts pointed out that there were relatively few such services to coordinate. After passage of the legislation, neither the administration nor the Congress demonstrated much enthusiasm for the program. Budget requests and congressional appropriations have been token, and as of 1981, only 27 projects have been initiated throughout the country. Although Congress has authorized a considerable expansion of publicly funded contraceptive services with special emphasis on services to teenagers, there has been no increase in actual appropriations. The continuing debate over abortion, and the Supreme Court's decision in 1980 that the Hyde Amendment was constitutional, have led to the virtual withdrawal of federal funds for abortions, a step likely to be a particular hardship for teenagers. Governmental support for sex education has been at a standstill, and few program innovations have been introduced. Funds to develop needed new effective and safe contraceptive methods have, in terms of constant dollars, actually diminished. Under the circumstances, it is perhaps not so surprising that teenage pregnancy rates have not been brought down.

Yet the considerable amount of information that has become available over the last few years about teenage pregnancy and its consequences (as summarized in the preceding charts and graphs) has not diminished our confidence that the kind of national program we broadly outlined in *11 Million Teenagers* could go a long way toward solving the problem. Experience suggests, however, that more emphasis needs to be placed on two aspects of such a program. These are reaching young people with information about sexuality, fertility control and reproduction before they become sexually active—indeed, before they reach puberty—and developing new, improved contraceptive methods.

During the last decade, the public has been made aware of problems involving the safety, practicability and acceptability of all currently available contraceptives, including the two most effective ones—the pill and the IUD. These problems affect all women of childbearing age, but they are particularly acute for teenagers, whose sexual lives are generally not firmly established and whose ability to assess risks and benefits may not be fully developed. Resort to sterilization at relatively young ages among the adult population and the increase in abortions and out-of-wedlock births, particularly among teenagers and young women, are the most obvious manifestations of the problem. The major source of support for contraceptive research in the United States (indeed, in the world) is the United States government, through the National Institutes of Health (NIH). A reassessment of research priorities at the NIH is urgently needed. Although the development and testing of new contraceptive methods can take years, the basic knowledge needed to produce considerable improvement of current contraceptive technologies in a relatively short time is available. The initiative rests with the Congress and the executive branch.

*For example, important recommendations are made in the 1978 report of the Select Committee on Population of the U.S. House of Representatives, the 1980 recommendations of the White House Conference on Families, the Surgeon General's 1979 Report on Health Promotion and Disease Prevention and his 1980 report setting the decade's health objectives for the nation, the 1980 Report of the President's Advisory Committee for Women, the Department of Health and Human Services' proposed 1980 National Guidelines for Health Planning, and the 1980 report of the congressionally mandated Select Panel for the Promotion of Child Health.

The second program emphasis—reaching young people before they become sexually active—will require widespread public support, legislative and administrative action at all levels of government, and the active partnership and participation of parents, churches, civic and professional organizations and the media.

Early Intervention

As we have seen, only 10 states and the District of Columbia require or encourage sex education; only one-fifth of secondary-school students live in those states. Where classes do exist, discussion of contraception and abortion is often prohibited. Most sex education classes, according to the Select Panel for the Promotion of Child Health, are "meager in content, limited in scope and too late in being presented."

We agree with the Select Panel that most sex education programs are too narrow in addressing only the most elementary facts about reproduction. But even these elementary facts are apparently presented ineffectively, since most teenage girls who have had a sex education course still do not know the time of month when they are at greatest risk of pregnancy—a crucial piece of information, since the major reason given by teenagers for not using contraceptives is the (often incorrect) belief that they are having intercourse at a time of month when they cannot conceive.

Young people need to know about the relative efficacy and safety of all contraceptive methods and about how they can obtain the services they require. Students need to learn about the availability of pregnancy testing and pregnancy counseling services, and of prenatal care and abortion services if they do become pregnant. They should be told about the health risks of abortion and the risks of carrying a pregnancy to term. Instruction about the health, social and economic consequences of early childbearing as well as about the responsibilities of parenthood is an integral part of a sex education program. Curricula and teaching materials, including a wide choice of books and films appropriate for different educational and community settings, are available for use at all grade levels. Thus, school systems can adapt existing curricula in order to implement instruction in sexuality and reproduction.

Parents want to be involved in teaching their children about sex, but many of them recognize that they are unprepared to do so. In a few communities, discussion groups, seminars and classes have been organized to give parents the skills required to talk to their children about sex. Many more such programs are needed. The active involvement of informed parents in school-based sex education programs is likely to increase acceptability and effectiveness of those programs. A small number of parents, however, are unalterably opposed to any kind of sex education programs on the grounds that only parents should transmit sexual knowledge and values to their children. In too many cases, they have intimidated school boards into abandoning proposed sex education courses or diluting them to the point where they have become ineffective. Their success in mobilizing support has probably depended on the fact that many parents fear that providing information about sex and contraception to their children will in itself encourage the young people to become sexually active. The evidence, however, suggests that uninformed teenagers are the most vulnerable to unwanted pregnancy, because they do not know how to keep from getting pregnant or because they feel guilty about using contraceptives. A good sex education course, far from making young people sexually promiscuous, can give them the confidence to resist premature or exploitative sexual experiences and to protect themselves from pregnancy when and if they do become sexually active.

Sex education, of course, need not and should not be restricted to the classroom and the home, but should be stressed by churches, youth agencies, health care programs and the media.

The problem is in getting the programs to where the teenagers are. By the time they come to a social agency or to a family planning clinic for help, many teenagers are already pregnant—or parents. That is one value of school-based programs: The youth are already there. But they are also enrolled in church groups and arts and recreation programs; they spend time in shopping malls and at rock concerts. Telephone "hot lines" have

proven effective in many communities in providing information and referrals to teenagers on a confidential basis. Reaching out to teenagers in the places where they spend their time and not waiting for teenagers in trouble to come for help is basic to an effective community-based sex education program.

The media—television, radio, newspapers and youth-oriented magazines—can play an important role in reaching teenagers before they get pregnant with information about reproductive health care, including sources of counseling and services. The most powerful message teenagers seem to be receiving from the media today is the explicitly sexual one delivered by almost every advertisement, for products ranging from designer jeans to toilet soaps. Meanwhile, even the most tasteful advertisements for contraceptives are banned from all TV and radio networks and from most local stations and newspapers.

Contraceptive Services

About 12 million adolescents are sexually active, and nearly five million young women risk unintended pregnancy each year while still in their teens. More than half of these women obtain contraceptives from family planning clinics or private physicians. Nearly 800,000, however, are sexally active and are using no means to protect themselves from pregnancy, while more than one million are depending on less effective nonprescription methods or ineffective folk methods like withdrawal. We agree with the U.S. Surgeon General in calling the elimination of unintended teenage fertility one of the nation's top health priorities for the 1980s and in urging the expansion of family planning services to accomplish this objective.

Many family planning clinics have the capacity and willingness to expand their adolescent caseloads. Given additional financial support—about $50 million in public funds—they probably could serve an additional one million adolescent patients. About $250 million in support for the family planning clinics now comes largely from Title X of the Public Health Services Act, which expires at the end of 1981 unless renewed by Congress, and from the Medicaid (Title XIX), the Maternal and Child Health (Title V), and Social Services (Title XX) sections of the Social Security Act. Medicaid reimbursement is a potential source of funding for indigent adolescents who obtain contraceptive services from either clinics or private physicians. For the many teenagers who are eligible for Medicaid only as part of their mothers' public assistance coverage, it is not possible to obtain services without parental involvement. In addition, in many states, the level of reimbursement for family planning services under Medicaid is so low that doctors and clinics are reluctant to accept Medicaid patients.

Although most teenagers apparently tell their parents about their decision to get birth control services, a minority do not and would not come for such assistance if parental notification were required. About one-fifth of family planning clinics now have some kind of parental consent requirement for teenage patients; it is probable that teenagers who seek services from private physicians are even more likely to face such requirements. We agree with the Select Panel for the Promotion of Child Health that

> every effort should be made to encourage young people, and especially younger adolescents, to communicate with their families about any care they are receiving. However, requirements of parental involvement must not be permitted to become a deterrent to the receipt of needed services, nor should receipt of services be contingent upon parental consent....Information must be held confidential and released only with the young person's consent; and confidentiality must be protected in establishing fees and billing for services.

Confidentiality, a sympathetic attitude toward teenagers, proximity and a reputation for high-quality services are among the major reasons young people give for choosing a particular source of contraceptive care. The ability to get services promptly without long waits for an appointment or in the clinic are also important. Much less significant, apparently, are the availability of rap sessions, special teen hours and attention to teen decor and atmosphere.

Teenagers seldom come for birth control help before or soon after beginning to have sexual intercourse. As a result, half of teenage

pregnancies occur in the first six months after initiation of sex. More intensive outreach and education efforts are needed to get to teenagers before they begin sexual activity. In addition to providing contraceptive services, family planning clinics need to be able to counsel young men and women about family planning *before* they become sexually active. Such preventive services are sometimes not supported by federal family planning funds unless the patient receives a medical examination and contraceptive services. Such policies should be revised in light of the importance of reaching young people before they risk unintended pregnancy.

Many adolescents first obtain contraceptives at their local drugstores or through private physicians. Yet pharmacists are too often a source of intimidation to teenagers when they could facilitate the choice of a contraceptive by making condoms and spermicides visible and easy to purchase. Little is known about how successful teenagers are in obtaining contraceptive prescriptions from private physicians on a confidential and sympathetic basis. Yet private doctors should be an important source of counseling and services.

If nonprescription contraceptives were openly displayed in drugstores and supermarkets and were made available through vending machines in public rest rooms and other areas where teenagers could obtain them without embarrassment, the use of such methods by young people might well be increased. Although barrier methods are not as effective as the pill, they may be more appropriate for teenagers who have intercourse infrequently, especially if they are willing and able to obtain an abortion in the event of an unintended pregnancy resulting from contraceptive failure.

No method currently available is really appropriate for young people who engage in sex only occasionally or intermittently. A postcoital or once-a-month method, which would be much more appropriate, could be developed with additional funding for contraceptive research. As we have noted, such research funding has declined in recent years. The investment in contraceptive development by the National Institutes of Health needs to be increased from $12 million to about $60 million to make available the needed new safe and effective methods that are more acceptable to teenagers and other groups.

Pregnancy Counseling

Most communities still lack adequate facilities to which teenagers can go for pregnancy testing, counseling and referral. Even where such facilities do exist, many teenagers do not know where to find them. Pregnancy testing can be provided through public health clinics, hospitals, family planning clinics, schools, even pharmacies. Home pregnancy tests are increasingly popular, but they are no substitute for a laboratory test and pelvic examination. If the pregnancy test is positive, the teenager needs nonjudgmental counseling outlining her options for prenatal care or legal abortion, as well as the necessary referral and follow-up. If her pregnancy test is negative, she needs contraceptive counseling and referral for birth control. Since nearly two-fifths of teenage family planning clinic patients come to the facility because of fear of pregnancy, most such clinics have established pregnancy testing and counseling programs. Abortion clinics, of course, also do pregnancy testing and examination, and many counsel the patient as to her options. Most patients at such clinics, however, already have made up their minds about what they are going to do if they are pregnant. Other services, such as Birthright, provide the pregnancy testing but refuse to discuss or refer for contraception if the teenager is not pregnant. If she is, they will vigorously attempt to dissuade her from seeking abortion, and encourage her to consider only the options of keeping the baby or giving it up for adoption. In general, pregnancy testing is far easier to obtain than realistic counseling and adequate referral.

Adherence to the principles of voluntarism and informed consent require at least that all programs provide their patients or clients with a list of the risks, benefits and consequences of maternity and abortion; the alternatives open to them, including adoption; and the resources available for needed care—whether abortion or prenatal and maternity services, social services or financial support.

Abortion Services

Serious problems of geographic inaccessibility of abortion services are exacerbated by increased costs and time required to obtain an abortion in a distant community, and teenagers' general lack of resources and familiarity with the medical system. Parental consent or notification requirements in two-fifths of abortion facilities also pose a serious problem for those teenagers who feel that they cannot tell their parents about their pregnancy.

The lack of availability and accessibility of abortion services forces many teenagers to have unintended births, and delays others to the point at which the abortion procedure is relatively more dangerous to their health and even their lives. The very necessity for travel to a distant community, even when the pregnancy is terminated early, involves greater health risk to the teenage patient, because complications may occur days after the procedure, when the young patient has returned home and cannot easily return for help to the physician who performed the abortion.

Requirements of parental consent serve only to panic some teenagers and delay needed care. Abortion facilities can encourage teenagers to involve parents without violating the patient's right to confidential and sympathetic treatment.

Although many abortion facilities provide contraceptive counseling and prescription as part of the overall service, a number do not. To prevent repeat pregnancies among teenage patients, it is important that services include detailed counseling about the efficacy and safety of the various contraceptive methods, as well as prescription of a method and arrangements for continuing contraceptive care through referral to a family planning clinic or physician of the patient's choice.

Health Care for Adolescent Mothers And Their Children

Despite improvement in prenatal-care services for mothers in all age-groups, many young mothers do not get prenatal care during the critical first three months of pregnancy and some get none at all. It has been established that timely and high-quality prenatal care can do much to prevent the serious health consequences to mother and infant of adolescent childbearing. Few teenage mothers have health insurance of their own or can afford to pay for their prenatal care and obstetrical services. (Even when they have health insurance, the costs of adequate care are generally far in excess of the insurance reimbursement.) The result is that young teenage mothers are far more likely than mothers in their 20s to have low-birth-weight babies and to see their babies die at birth or in infancy, and are much more likely themselves to die or suffer from serious complications of childbirth.

Federally funded special maternity and infant care programs and scattered comprehensive teenage reproductive health programs in some of the nation's large cities have proven their effectiveness in reducing the consequences of adolescent motherhood. But such programs are still absent from most communities.

The Select Panel for the Protection of Child Health has put prenatal, delivery and postnatal care at the top of those three classes of services which it considers essential for the health *of all* women of reproductive age and their children (the others are comprehensive health care for children through age five and family planning services). Although the benefits of high quality and timely prenatal, obstetric and postnatal care and care of the young child are almost universally acknowledged, progress to extend such care to young mothers living in communities throughout the nation has been extremely slow, largely due to an unwillingness to invest the necessary public funds.

Social Programs for Adolescent Parents And Their Children

Special programs are needed to help young parents complete their educations, train for and obtain decent jobs, get day care for their babies (so that they can work or go to school), learn the skills necessary to bring up their children, get needed psychological counseling and obtain financial assistance where required.

Because of legal requirements to provide continuing education, pregnant teenagers are no longer automatically expelled from school,

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Figure 10. Number of births: National Center for Health Statistics, DHHS (NCHS), "Final Natality Statistics, 1978," *Monthly Vital Statistics Report*, Vol. 29, No. 1, 1980. **Number of women obtaining abortions, by age:** S. Henshaw, J. D. Forrest, E. Sullivan and C. Tietze, "Abortion in the United States, 1978–1979," *Family Planning Perspectives*, 13:6, 1981. **Marital status of women obtaining abortions, by age and race:** Special tabulation by C. Tietze, The Population Council, based on statistics from the Ohio State Health Department and the Centers for Disease Control, DHHS (CDC). **Miscarriages:** Estimate adapted from model developed by C. Tietze and J. Bongaarts of The Population Council (20 percent of births and 10 percent of abortions). **Percentage of marital births conceived premaritally:** M. O'Connell and M. J. Moore, "The Legitimacy Status of First Births to U.S. Women Aged 15–24, 1939–1978," *Family Planning Perspectives*, 12:16, 1980; and unpublished tabulations from Current Population Surveys from M. O'Connell, U.S. Bureau of the Census, 1981. (All marital births to girls under age 15 are assumed to have been premaritally conceived.) **Number of pregnancies:** The sum of births, abortions and miscarriages occurring in 1978.

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Figure 12. Number of pregnancies: See notes to Figure 11. **Number of women, by age:** U.S. Bureau of the Census, *CPR*, Series P-25, No. 876, GPO, 1980, Table 1. **Sexually active women, by age:** Tabulations by J. G. Dryfoos, using trend data on sexual activity from the Johns Hopkins Surveys of Young Women, 1971, 1976 and 1979 (see notes to Figures 1 and 2).

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Figure 14. Tabulations by J. G. Dryfoos, based on **number of pregnancies, births and abortions, by age and marital status of mother**—see notes to Figure 10; **pregnancy intentions, by marital status and race, for currently married women aged 15–19**—unpublished tabulations of 1976 National Survey of Family Growth from J. Anderson, CDC; **for unmarried women aged 15–19**—M. Zelnik and J. F. Kantner, "First Pregnancies to Women Aged 15–19, 1976 and 1971," *Family Planning Perspectives*, **10**:11, 1978, Tables 5 and 11. It is assumed that the rate of unintended births is higher among mothers younger than 18 than among mothers aged 18–19, and that all abortions are of unintended pregnancies.

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Figure 16. C. Tietze, "Teenage Pregnancies: Looking Ahead to 1984," *Family Planning Perspectives*, **10**:205, 1978.

Figure 17. See notes to Figure 10.

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Figure 19. NCHS, "Final Natality Statistics, 1978," 1980, op. cit., Table 4 (see notes to Figure 10).

Figure 20. Out-of-wedlock birthrates, by age and race, 1970–1975: S. Ventura, "Teenage Childbearing: United States, 1966–1975," *Monthly Vital Statistics Report*, NCHS, Vol. 26, No. 5, 1977. **1976:** NCHS, "Final Natality Statistics, 1976," 1978, op. cit. (see notes to Figure 11). **1977:** NCHS, "Final Natality Statistics, 1977," 1979, op. cit. (see notes to Figure 11). **1978:** NCHS, "Final Natality Statistics, 1978," 1980, op. cit., Table 13 (see notes to Figure 10).

Figure 21. First births, by legitimacy status: Tabulations by J. G. Dryfoos, extrapolated from vital statistics, using total births, out-of-wedlock births, first births and percentage of out-of-wedlock births known to be first births from NCHS, *Vital Statistics of the United States, Vol. I, Natality*, for the years 1970–1972 and 1975, GPO, 1975, 1975, 1976 and 1978. 1976 figures are from NCHS, "Final Natality Statistics, 1976," 1978, op. cit. (see notes to Figure 11). 1977 and 1978 figures are from unpublished data from S. Ventura, NCHS Natality Division. **Percentage of first marital births premaritally conceived:** Unpublished tabulations from M. O'Connell, 1981, op. cit. (see notes to Figure 10).

Figure 22. M. Zelnik and J. F. Kantner, "First Pregnancies . . . ," 1978, op. cit., Table 6 (see notes to Figure 14).

Figure 23. Tabulations by J. G. Dryfoos aggregating number of births, first births and out-of-wedlock births by single years of age of the mother to estimate (1) number of women younger than 20 who became mothers (first births to women aged 15–19 in 1978 plus first births to women aged 14–18 in 1977, etc.); (2) number of total and out-of-wedlock births occurring to women younger than 20 in previous five years (total births to women aged 15–19 in 1978 plus total births to women aged 14–18 in 1977, etc.); and (3) number of children born during past five years to women who were teenagers (all births to women younger than 20 in 1974–1978).

Figure 24. Infant mortality: Calculated from New York State Department of Health, *Quarterly Vital Statistics Review*, 1980, Table 6. **Maternal mortal-**

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Figure 30. U.S. Bureau of the Census, "Characteristics of the Population Below Poverty Level: 1978," *CPR*, Series P-60, No. 124, GPO, 1980, Table 19.

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Figure 32. Percentage of teenage parents, according to their parents' age at first birth: Special tabulations from J. J. Card and L. Steel, Project TALENT, American Institutes for Research in the Behavioral Sciences (a project supported by the U.S. Office of Education and the National Institute of Education). **Percentage of mothers younger than 16 with teenage mothers:** Unpublished data from S. H. Miller, Child Welfare League of America, 1981.

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Figure 40. Method used before and after last clinic visit, 1976: AGI, *Data and Analyses for 1977 Revision of DHEW Five-Year Plan for Family Planning Services*, New York, 1977. **Method used at last clinic visit, 1978:** Unpublished tabulations from NRSFPS sample survey of family planning patients, 1978. **Percentage of sexually active unwed teenagers who got first prescription for pills from clinics:** M. Zelnik and J. F. Kantner, "Sexual and Contraceptive Experience ...," 1977, op. cit., Table 14 (see notes to Figure 1).

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Figure 55. Ibid., Table 9.

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Figure 60. Ibid., Table 6.

Figure 61. Adolescent mothers, by single years of age: See notes to Figure 23. **Percentage who have not completed high school, by age:** Calculated by J. G. Dryfoos from NCHS, "Final Natality Statistics, 1978," 1980, op. cit., Table 16 (see notes to Figure 10). Same distribution for previous five years assumed.

Figure 62. Tabulations by J. G. Dryfoos, based on **number of children of teen mothers, by single years of age**—see notes to Figure 23; **number of children, by single years of age**—U.S. Bureau of the Census, "Population Estimates and Projections," *CPR*, Series P-25, No. 870, GPO, 1980, Table 1; **number in day care, for all children enrolled**—Abt Associates, *Day Care Centers in the U.S.*, Cambridge, Mass., 1979, Table 49 (assumed that proportion of children of any given age who have teenage mothers is the same for those in day care as in the general population); **person caring for child**—U.S. Bureau of the Census, "Daytime Care of Children, 1975," *CPR*, Series P-20, No. 298, GPO, 1976.

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